### No. 82728-1

# IN THE SUPREME COURT OF THE STATE OF WASHINGTON

OVERLAKE HOSPITAL ASSOCIATION and OVERLAKE HOSPITAL MEDICAL CENTER, Washington nonprofit corporations; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, d/b/a EVERGREEN HEALTHCARE, a Washington Public Hospital District,

Respondents,

v.

DEPARTMENT OF HEALTH OF THE STATE OF WASHINGTON, and SWEDISH HEALTH SERVICES,

### Petitioners.

#### RESPONDENTS' SUPPLEMENTAL BRIEF

Donald W. Black E. Ross Farr Attorneys for Overlake Hospital Medical Center Ogden Murphy Wallace, P.L.L.C. 1601 Fifth Avenue, Suite 2100 Seattle, Washington 98101-1686 Tel: 206-447-7000

James S. Fitzgerald
Gregory A. McBroom
Attorneys for Evergreen Healthcare
Livengood, Fitzgerald &
Alskog, PLLC
121 Third Avenue
Kirkland, Washington 98033
Tel: 425-822-9281

STATE OF WASHINGTON

2009 AUG 31 AM 7: 56

BY KONALD R. CARPENTER

CLERK

ORIGINAL

### TABLE OF CONTENTS

		Page
A.	SUM	MARY OF ARGUMENT1
B.	ARGU	UMENT4
	1.	Swedish Falsely Asserts A Need Exists For An Ambulatory Surgical Facility in Bellevue4
	2.	The Court of Appeals Granted the Appropriate Amount of Deference and Appropriately Interpreted the Methodology Consistently and Uniformly Throughout
		a. The Department's Final Order Acknowledges Inconsistent Application of the Same Terms9
		b. The Department's Interpretation of the Methodology was Inconsistent with the Legislative Policy
	3.	The Court of Appeals Has Not Altered Healthcare Policy or Access to Care in Washington
	4.	The Court of Appeals Did Not "Infringe" on the Department's Authority to Set Health Planning Policy16
	5.	Examples of Past "No-need" Determinations Do Not Justify Reversing the Court of Appeals
	6.	The Department's Past Misapplication and Erroneous Interpretation Does Not Justify Reversal18
C.	CONCLUSION19	
APPE	NDIX	A-1

# TABLE OF AUTHORITIES

## Cases

Children's Hospital and Medical Center v. Wash. St. Dep't of Health, 95 Wn. App. 858, 864-65 n. 12, 975 P.2d 567 (Div. 2 1999) review denied 139 Wn.2d 1021, 994 P.2d 847 (2000)
Dep't of Labor and Indust. v. Granger, 159 Wn.2d 752, 764, 153 P.3d 839 (2007)
Mader v. Health Care Auth., 149 Wn.2d 458, 473, 70 P.3d 931 (2003) 12
Overlake Hospital Medical Center and Evergreen Healthcare, Dept. of Health Docket No. 03-06-C-2005CN, Findings of Fact, Conclusions of Law and Order of Remand
Overlake v. Dep't of Health, 148 Wn. App. 1, 200 P.3d 248 (2008) 1, 6
Providence Hosp. of Everett v. Dep't of Soc. & Health Servs., 112 Wn.2d 353, 355-56, 770 P.2d 1040 (1989)
Safeco Ins. Co. v. Meyering, 102 Wn.2d 385, 392, 687 P.2d 195 (1984) 7
Silverstreak, Inc. v. Dep't of Labor and Industries, 159 Wn.2d 868, 154 P.3d 891 (2007)8
St. Joseph Hosp. v. Dep't of Health, 125 Wn.2d 733, 735, 887 P.2d 891 (1995)
State v. McGinty, 80 Wn. App. 157, 160, 906 P.2d 1006 (1995)
Tesoro Refining v. Dep't of Revenue, 163 Wn.2d 310, 317, 190 P.3d 28 (2008)
Univ. of Wash. Med. Ctr. v. Wash. State Dep't of Health, 164 Wn.2d 95, 102, 187 P.3d 243 (2008)
White v. Salvation Army, 118 Wn. App. 272, 277, 75 P.3d 990 (2003) 8
Statutes
Chapter 34.05 RCW17

### Other Authorities

Fisher, Elliot; Goodman, David; Skinner, Jonathan; Bronr Health Care Spending, Quality and Outcomes; More Is Better, Dartmouth Institute For Health Policy & Clinica (February 27, 2009)	<i>n't Always</i> al Practice
Gaffney, Mark; Martin Zimmerman, An old-fashioned way costs; Well-run certificate-of-need programs can help r healthcare spending, Modern Healthcare (Crain Comm 2002)	ein in rising unications, Inc.
Regulations	
WAC 246-310-010	11
WAC 246-310-270(9)	1, 10, 13

### A. SUMMARY OF ARGUMENT

Overlake Hospital Association and Overlake Hospital Medical Center (collectively "Overlake") and King County Public Hospital District No. 2, d/b/a Evergreen Healthcare ("Evergreen") respectfully request that this Court affirm the Court of Appeals' holding in *Overlake v. Dep't of Health*, 148 Wn. App. 1, 200 P.3d 248 (2008). The Court of Appeals' holding should be upheld because, in a well reasoned decision, it appropriately reversed the internally inconsistent application of the methodology (WAC 246-310-270(9), the "Methodology"), which the Department of Health (the "Department") uses to determine whether new ambulatory operating rooms are needed within a health planning area. <sup>1</sup> It correctly determined that the Department must interpret its regulation in a consistent and uniform manner. The Court of Appeals did not change the law; it accurately and rationally read the plain language of the Methodology, and instructed the Department to apply it correctly.

The narrow issue before the Court is whether the terms within the Methodology should be interpreted consistently throughout. In more specific terms, whether the plain language requires the Department to

<sup>&</sup>lt;sup>1</sup> The Methodology is attached to this Brief as APPENDIX A.

uniformly use the same surgical facilities for determining existing capacity and future need, or whether the plain language requires the Department to use a widely different count of existing surgical facilities depending on whether it is calculating existing capacity or future need.

As Overlake's and Evergreen's brief to the Court of Appeals explains, even the Department's hearing officer (the "Health Law Judge") acknowledged that the plain language of the Methodology states that the same surgical facilities should be used when calculating existing capacity and future need.<sup>2</sup> However, the Health Law Judge then erred by openly abandoning the plain language of the Methodology and concluding that the number of future surgeries should be projected using data from a larger set of operating rooms than used to calculate the existing capacity of the planning area.<sup>3</sup> As Overlake's and Evergreen's principal briefing further explains, this unbalanced approach artificially inflates the need for new operating rooms, is contrary to the plain language within the Methodology, the legislative policy behind the certificate of need program, and common sense. The Court of Appeals correctly rejected this imbalanced approach.

<sup>&</sup>lt;sup>2</sup> CP 13-31 (The Department's Final Order) (APPENDIX B).
<sup>3</sup> Id.

Swedish and the Department have no principled rationale for the Department's unbalanced, extra-textual reading of the Methodology. They describe a non-existent threat to health policy and resort to unsupported arguments regarding "patient choice" and "access to healthcare." They have no evidentiary support for these arguments. No crisis of access to ambulatory surgery exists in East King County; to the contrary, the record demonstrates that East King County had more operating rooms than it needed at the time of Swedish's application.

The Court of Appeals did not "change" the law; it *corrected* an erroneous interpretation of the law by correcting the mathematical application of the Methodology by using terms consistently and uniformly throughout. This also realigned the application of the Methodology with the legislature's policy goals. The legislature determined that overcapacity of health care facilities tends to further drive up health care costs. *St. Joseph Hosp. v. Dep't of Health*, 125 Wn.2d 733, 735, 887 P.2d 891 (1995). When the Methodology is applied as written, it furthers the legislature's purpose of building only needed ambulatory surgical facilities. It is the correct application of the Methodology that determines whether a shortage of operating rooms exists.

### B. ARGUMENT

1. <u>Swedish Falsely Asserts A Need Exists For An Ambulatory</u> <u>Surgical Facility in Bellevue</u>.

The record demonstrates that no emergent need existed for additional operating rooms in the East King County Planning area, despite Swedish's unsupported contentions. Excess capacity existed in operating rooms in the East King County planning area at the time of Swedish's certificate of need application. AR-I 373. Snoqualmie Valley Hospital ("Snoqualmie") had two vacant operating suites. AR-I 373-74. Snoqualmie offered them to Swedish, but Swedish declined and chose to apply for certificate of need to open a new facility. AR-I 373-74. Overlake Surgery Center, an operational Ambulatory Surgical Center located in Bellevue, was only at 56% capacity. AR-I 379. Evergreen Surgery Center, an operational Ambulatory Surgical Center in Kirkland, had capacity to "more than double" its volume of surgeries. AR-I 408; see also AR-I 411.

The public comments in support of Swedish's application did not emphasize the need for new operating rooms in the East King County

<sup>&</sup>lt;sup>4</sup> Swedish's Petition for Review at 4.

<sup>&</sup>lt;sup>5</sup> The following documents from the administrative record (AR-I) are collectively attached hereto as APPENDIX C.

planning area; instead they emphasized convenience for Swedish physicians who live east of Lake Washington and discussed Swedish's patients' "brand loyalty" to Swedish. AR-I 382, 405, 410. Swedish physicians emphasized wanting to perform surgeries on the Eastside in a new Swedish facility, but omitted the option of seeking privileges to perform surgeries at one of the existing under-capacity surgical facilities. *See, e.g.* AR-I 413.

"Brand loyalty" to Swedish and convenience for its physicians does not equate to a need for new operating rooms when a surplus of operating rooms already exists. Swedish's desire to perform surgeries at its own facilities, rather than use excess existing surgical capacity in the East King planning area, should not determine whether a need exists for new operating rooms.<sup>6</sup>

<sup>&</sup>lt;sup>6</sup> In an earlier case involving this same certificate of need application by Swedish, Swedish argued that it should not have to use the standard boundaries of the East King Planning area for determining whether a need existed. *See e.g.*, CP 424. This is not at issue in the present case because Swedish was told it had to use the same planning area definitions as all other providers. However, this underscores Swedish's adherence to its own exceptionalism: it believes it does not have to obey the same rules that others do.

2. The Court of Appeals Granted the Appropriate Amount of Deference and Appropriately Interpreted the Methodology Consistently and Uniformly Throughout.

The first sentence of the Court of Appeals' opinion recognizes the proper level of deference to the Department, which states:

Although a high level of deference is accorded to an agency's determination under the Administrative Procedure Act,[] such deference will not lie where an agency's decision is based on an implausible interpretation of its regulations.

Overlake Hosp. v. Dep't of Health, 148 Wn. App. at 3 (footnote omitted).

The Court of Appeals' statement of the law is consistent with this Court's recent affirmation of the standard of review in certificate of need cases, which requires a court to closely examine an agency's interpretation of a regulation for adherence to the legislative policy behind the regulation, and then balance the court's own analysis with the agency's expertise in implementing the legislative policy:

The error of law standard permits this court to substitute its interpretation of the law for that of the agency, but we accord substantial deference to the agency's interpretation, particularly in regard to the law involving the agency's special knowledge and expertise.

Univ. of Wash. Med. Ctr. v. Wash. State Dep't of Health, 164 Wn.2d 95, 102, 187 P.3d 243 (2008) (quoting Providence Hosp. of Everett v. Dep't of Soc. & Health Servs., 112 Wn.2d 353, 355-56, 770 P.2d 1040 (1989) (citations omitted).

This standard is not a rubber-stamp of the agency's interpretation of the law, contrary to the assertions of Swedish and the Department. Courts have the "ultimate responsibility to see that the rules are applied consistently with the policy underlying the statute." *Safeco Ins. Co. v. Meyering*, 102 Wn.2d 385, 392, 687 P.2d 195 (1984). An agency's interpretation must be plausible and consistent with the intent of the legislature. *Dep't of Labor and Indust. v. Granger*, 159 Wn.2d 752, 764, 153 P.3d 839 (2007) ("an agency's interpretation is not binding on us, and deference to an agency is inappropriate where the agency's interpretation conflicts with a statutory mandate.")

This standard has been consistently applied by the Court of Appeals. See, e.g., Children's Hospital and Medical Center v. Wash. St. Dep't of Health, 95 Wn. App. 858, 864-65 n. 12, 975 P.2d 567 (Div. 2 1999) review denied 139 Wn.2d 1021, 994 P.2d 847 (2000) (citing Nielsen v. Employment Security Dep't, 93 Wn. App. 21, 29, 966 P.2d 299 (1998)) (courts properly "reject[] an agency's interpretation of its own rule that,

although plausible, [is] inconsistent with the expressed intent of the Legislature.") An agency must logically interpret its own regulations. See White v. Salvation Army, 118 Wn. App. 272, 277, 75 P.3d 990 (2003); State v. McGinty, 80 Wn. App. 157, 160, 906 P.2d 1006 (1995) ("Rules of statutory construction, which apply equally to administrative rules and regulations, require statutes to be given a rational, sensible construction"). An administrative interpretation of the law is accorded deference only according to "the validity of its reasoning." White, 118 Wn. App. at 277. No deference is given to an agency's interpretation of the law that is wrong. See White, 118 Wn. App. at 277.

Here, the Department's interpretation was both implausible and inconsistent with the plain language of the Methodology — a mathematical formula — and the legislative intent. The Department's actions, therefore, are distinguished from cases in which this Court has affirmed an agency's interpretation of its own rule. *Compare Silverstreak, Inc. v. Dep't of Labor and Industries*, 159 Wn.2d 868, 154 P.3d 891 (2007) ("Because the Department's interpretation . . . neither conflicts with the legislative intent nor exceeds the scope of its authority, it should be given proper deference here.") Here, the Court of Appeals appropriately determined that correcting an implausible interpretation of

the rule, which was contrary to the legislative intent to control costs by limiting competition,<sup>7</sup> outweighed deference to the agency.

### a. <u>The Department's Final Order Acknowledges</u> Inconsistent Application of the Same Terms.

The Department's Final Order acknowledges that it inconsistently applied the same terms within the Methodology. CP 28-29 (APPENDIX B). The Department, however, then erred in determining there was a need for additional future outpatient operating rooms in the East King County planning area by failing to consistently interpret the phrase "all outpatient operating rooms" as it is found in WAC 246-310-270(9). Specifically, when the Department interpreted that phrase for projecting future need, the Department *included* Exempt Surgical Facilities, but then *excluded* these same Exempt Surgical Facilities when it interpreted that term for purposes of determining existing capacity. CP 29 (APPENDIX B)

The Health Law Judge acknowledged that "The plain language of the rule does not differentiate between exempt (ambulatory surgical

<sup>&</sup>lt;sup>7</sup> St. Joseph Hospital, 125 Wn.2d at 741.

<sup>&</sup>lt;sup>8</sup> Consistent with earlier briefing, the term "Ambulatory Surgical Facility" (also known as "Ambulatory Surgical Centers" or "ASFs" or "ASCs") will refer to only those ambulatory operating rooms that require a certificate of need review and approval to operate. For purposes of this brief, ambulatory operating rooms that do not require a certificate of need will be referred to as "Exempt Surgical Facilities." An Ambulatory Surgery Facility is defined as "any free-standing entity, including an ambulatory surgery center, that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization." WAC 246-310-010.

centers) and non-exempt (ambulatory surgical facilities)." CP 28, ¶ 2.7 (APPENDIX B). He found the statutory language to be "all inclusive" of exempt and non-exempt facilities in the calculation of both future demand and existing capacity. CP 29, ¶ 2.8 (APPENDIX B). But, he then departed from the plain language based on an erroneous reading of the legislative policy: access to healthcare without regard to the cost-control function of the certificate of need program. CP 29, ¶ 2.9 (APPENDIX B). This approach was directly contrary to the plain language rule of statutory and regulatory construction. "If the meaning of the statute is plain, the court discerns legislative intent from the ordinary meaning of the words." Tesoro Refining v. Dep't of Revenue, 163 Wn.2d 310, 317, 190 P.3d 28 (2008).

For the Methodology to make sense, Exempt Surgical Facilities must be either consistently included or excluded when calculating both future need and existing capacity to meet that need; in other words, on both sides of the need/capacity equation. Otherwise, the Methodology yields an incorrect and meaningless result for health planning by creating a non-existent need for additional operating rooms.

To summarize, the Department's Final Order used the following illogical reasoning when interpreting the plain language of the Methodology:

- The plain language of the Methodology requires including Exempt Surgical Facilities in the projection of future need under WAC 246-310-270(9)(b)(i) (the *need* side of the equation);
- The plain language of the *capacity* side of the equation also "appears to be all inclusive [of Exempt Surgical Facilities]" under WAC 246-310-270(9)(a)(iii);
- However, despite this accurate reading of the plain language, the plain language on the *capacity* side of the equation under WAC 246-310-270(9)(a)(iii) should be abandoned in favor of a misguided interpretation of the legislative intent.

### AR-I 28-29 (APPENDIX B).

No court should defer to the Department when, as here, the Department had committed such an obvious error by disregarding the plain language of its own rule. No deference to the Department's specialized knowledge is required because the Methodology is a defined series of mathematical calculations, which are described by a series of terms that can and should be used consistently throughout the Methodology. This does not require any specialized knowledge of health

<sup>&</sup>lt;sup>9</sup> The Department's final decision states "[t]he decision whether to grant or deny an ambulatory surgery surgical facility certificate of need application is determined by using a mathematical formula or methodology to determine whether there is a "need" for an additional facility . . . . " APPENDIX B (CP 19).

planning. See Mader v. Health Care Auth., 149 Wn.2d 458, 473, 70 P.3d 931 (2003); Children's Hospital, 95 Wn. App. at 873.

Applying the same terms consistently is required by the principles of statutory construction, and it does not require expertise in health planning. The doctrine of agency deference was never intended to be an excuse to avoid the well-established principles of statutory construction, especially when, as here, the Department and Swedish inappropriately used it to divert attention from their mathematically nonsensical application of the Methodology.

b. The Department's Interpretation of the Methodology was Inconsistent with the Legislative Policy.

The Department's justification for ignoring the plain language of the Methodology was to ensure access. However, the Department ignored the stated legislative goal of ensuring access while controlling costs by limiting competition between providers:

While the Legislature clearly wanted to control health care costs to the public, equally clear is its intention to accomplish that control by limiting competition within the health care industry. The United States Congress and our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down

and government therefore needed to restrain marketplace forces. The means and end here are inextricably tied.

St. Joseph Hospital, 125 Wn.2d at 741. The Court of Appeals correctly brought the application of the Methodology back in line with this legislative policy. Recent studies have confirmed that the correct application of certificate of need regulation may be a significant factor in reducing the rise in health care costs, while improving access and the quality of care. For example:

In analyzing their own healthcare costs, DaimlerChrysler, Ford Motor Co. and General Motors Corp. . . . reported to the Michigan Legislature about analyses of their traditional and PPO health costs. Each company examined data from states where they have many employees and retirees. They reported that in every year analyzed, they had lower per-person health costs in states with CON than in states without such laws.

### APPENDIX D.10

To fulfill this policy, certificate of need regulation, such as the Methodology at issue here, must not only ensure access to care, but must

<sup>&</sup>lt;sup>10</sup> Gaffney, Mark; Martin Zimmerman, An old-fashioned way to control costs; Well-run certificate-of-need programs can help rein in rising healthcare spending, Modern Healthcare (Crain Communications, Inc. 2002) (emphasis added). See also, Fisher, Elliot; Goodman, David; Skinner, Jonathan; Bronner, Kristen, Health Care Spending, Quality and Outcomes; More Isn't Always Better, Dartmouth Institute For Health Policy & Clinical Practice (February 27, 2009) (APPENDIX E).

control the unnecessary addition of new facilities, which tends to drive up costs. The Methodology can only fulfill this policy goal if it is applied correctly, using the same terms consistently throughout.

# 3. The Court of Appeals Has Not Altered Healthcare Policy or Access to Care in Washington.

In its Petition for Review, Swedish has cynically attempted to create a false sense of emergency regarding access to care, citing to general national studies that speak to the popularity of ambulatory surgery as a justification for ignoring the plain language of the Methodology. The popularity of ambulatory surgery has no bearing on whether a need for more operating rooms exists in the East King County planning area.

The Department and Swedish misstate and exaggerate the impact of the Court of Appeals decision on the public at large by arguing that the public's access to, and choice of, operating rooms will be restricted. These are misleading and unsupported arguments because patients choose doctors, not surgical facilities. Members of the public do not simply walk into either an Ambulatory Surgical Facility or an Exempt Surgical Facility and request a surgery. Instead, patients consult with their physicians, who recommend surgery, which is then performed in an available facility,

which may be a private Exempt Surgical Facility, an Ambulatory Surgery Facility, or a hospital.

Most physicians who have Exempt Surgical Facilities in their private offices also have privileges at a hospital, Ambulatory Surgical Facility, or both. Access to health care in the context of surgery means access to physicians, not to operating rooms. This argument, therefore, does not justify deliberately misapplying the Methodology to create an oversupply of operating rooms. When the Methodology is applied correctly to the facts in the administrative record, no need exists for Swedish's proposed Ambulatory Surgery Center in Bellevue. *See* Appendix 11 to Overlake's and Evergreen's principal Brief on Appeal. 11

Finally, the implication that there must be an oversupply of Ambulatory Surgical Centers to accommodate all surgeries currently performed in Exempt Surgical Facilities in private physicians' offices is another red herring in an attempt to fabricate a public impact. There is no indication in the record or otherwise that there is now, or will be in the future, a lack of Exempt Surgical Facilities to accommodate the surgeries that are currently performed in them. No data exists to suggest that

<sup>&</sup>lt;sup>11</sup> Swedish has received a certificate of need to build a hospital in Issaquah, meaning that it will have available operating rooms in the East King County planning area.

Exempt Surgical Facilities are going to suddenly disappear. Therefore, any implication that Washington's health planning policy will be derailed by the Court of Appeals requiring the Department to follow the plain language of its own Methodology is absurd, and it is not a basis for reversal of the Court of Appeals.

# 4. The Court of Appeals Did Not "Infringe" on the Department's Authority to Set Health Planning Policy.

The Court of Appeals corrected the Department's interpretation of the Methodology to bring it in line with the language of the Methodology and the policy of the legislature. It did not infringe on the Department's authority over health planning policy. Nor did the Court of Appeals change the rules for approving ambulatory surgical facilities. The Court appropriately required the Department to adhere to its own rules and the legislative policy behind the certificate of need program, as has been recognized by this Court. *St. Joseph Hospital*, 125 Wn.2d at 741.

The Department retains full authority to engage in rulemaking, consistent with its legislative mandate and pursuant to the requirements of Washington's Administrative Procedure Act (the "APA"), chapter 34.05 RCW. If it wishes to adjust the Methodology, APA rulemaking is the proper route for it to do so.

# 5. <u>Examples of Past "No-need" Determinations Do Not Justify Reversing the Court of Appeals.</u>

Swedish tries to distract from the Court of Appeals' straightforward holding on the plain language of the Methodology by arguing that even the Department's misguided application of the Methodology will result in a finding of no need for more operating rooms under some circumstances. This is a red herring because the Court of Appeals was correct that the Department's "implausible interpretation" of the Methodology "will inevitably be biased toward need." *Overlake*, 148 Wn. App. at 3. This bias exists because, even with no population growth, the Methodology, as applied by the Department, would likely show a need for more operating rooms in planning areas with large amounts of surgeries performed in Exempt Surgical Facilities.

Nevertheless, in a few circumstances, an overwhelming surplus of existing Ambulatory Surgical Facilities or hospitals with operating rooms, or a small amount of surgeries performed in Exempt Surgical Facilities may could overcome the large bias and result in a finding of no need for more operating rooms, even under the Department's misapplication of the Methodology. One example is *In Re MultiCare Health System Gig Harbor Ambulatory Surgery Center* (Wash. Dep't of Health Dec. 13,

2007) ("In re MultiCare"). In In Re MultiCare, the Central Pierce planning area had an oversupply of operating rooms, which was large enough to overcome the bias in the Methodology for finding a need for more operating rooms. However, an improper bias still existed in the Department's interpretation and application of the Methodology, regardless of whether a large surplus of operating rooms overcame the bias and resulted in a no-need finding. In Re MultiCare does not justify reversing the Court of Appeals.

# 6. <u>The Department's Past Misapplication and Erroneous Interpretation Does Not Justify Reversal.</u>

The Department's past erroneous interpretation of the Methodology does not mean it may continue to misapply the Methodology, nor does it justify reversal. The Department has corrected itself in the past. For example, in a previous certificate of need case regarding the correct application of a need methodology for open-heart surgery facilities, the Department's health law judge ruled:

[t]he method of calculating current capacity is a question of law rather than an issue of fact, and the [Department] is not estopped from correcting its calculations consistent with the regulatory language even though it consistently calculated current capacity

using a different interpretation of the same regulatory language.

Overlake Hospital Medical Center and Evergreen Healthcare, Dept. of Health Docket No. 03-06-C-2005CN, Findings of Fact, Conclusions of Law and Order of Remand, p. 2 (attached hereto as APPENDIX F) (emphasis added). In that case, the Department had no reservation about correcting itself. *Id.* 

This prior certificate of need decision illustrates that the Department has recognized that it must correct itself when its interpretations of its own regulatory language have been wrong. Unfortunately, the Department did not do so here, so the Court of Appeals was required to correct the wrong interpretation of the need Methodology. Nevertheless, corrections to the Department's application of certificate of need methodologies do not automatically create calamity and public harm, as the unsupported claims of Swedish and the Department suggest. The Department and Swedish are wrong to make those unsubstantiated claims now, and the Court of Appeals should be affirmed.

### C. CONCLUSION

The Department erred by failing to properly interpret the plain language of the Methodology, instead using a mathematically nonsensical

application of the Methodology that resulted in an oversupply of Ambulatory Surgical Facilities in the East King County service area. This result was contrary to the express legislative policy for the certificate of need program. The Methodology should be interpreted and applied consistently rather than differently within different parts of the same rule. For these reasons, and the reasons stated in their briefing to the Court of Appeals, Overlake and Evergreen respectfully ask this Court to affirm the Court of Appeals' decision.

RESPECTFULLY SUBMITTED this 27 day of August, 2009.

OGDEN MURPHY WALLACE, P.L.L.C.

Bv

Donald W. Black, WSBA #25272

E. Ross Farr, WSBA #32037

Attorneys for Respondents

Overlake Hospital Medical Center

LIVENGOOD, FITZGERALD & ALSKOG, PLLC

**D**37

James S. Fitzgerald, WSBA #8426

Gregory A. McBroom, WSBA #33133

Attorneys for Respondents

King County Public Hospital District No. 2,

d/b/a Evergreen Healthcare

#### **APPENDICES**

- A. WAC 246-310-270(9), the "Methodology";
- B. The Department of Health's Final Order, CP 13-31;
- C. Public Comments Submitted to the Department of Health during review of Swedish's application to establish an Ambulatory Surgery Center in Bellevue, AR-I 373-413;
- D. Gaffney, Mark; Martin Zimmerman, An old-fashioned way to control costs; Well-run certificate-of-need programs can help rein in rising healthcare spending, Modern Healthcare (Crain Communications, Inc. 2002);
- E. Fisher, Elliot; Goodman, David; Skinner, Jonathan; Bronner, Kristen, *Health Care Spending, Quality and Outcomes; More Isn't Always Better*, Dartmouth Institute For Health Policy & Clinical Practice (February 27, 2009); and
- F. Overlake Hospital Medical Center and Evergreen Healthcare,
  Dept. of Health Docket No. 03-06-C-2005CN, Findings of Fact,
  Conclusions of Law and Order of Remand

# **APPENDIX A**



WA ADC 246-310-270

WAC 246-310-270

Wash. Admin. Code 246-310-270

Page 1

### WASHINGTON ADMINISTRATIVE CODE TITLE 246. HEALTH, DEPARTMENT OF CHAPTER 246-310. CERTIFICATE OF NEED

Current with amendments adopted through October 3, 2007.

246-310-270. Ambulatory surgery.

- (1) To receive approval, an ambulatory surgical facility must meet the following standards in addition to applicable review criteria in WAC 246-310-210, 246-310-220, 246-310-230, and 246-310-240.
- (2) The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.
- (3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, Central King, Southwest King, Southeast King, Central Pierce, West Pierce, East Pierce, Mason, West Grays Harbor, Southeast Grays Harbor, Thurston, North Pacific, South Pacific, West Lewis, East Lewis, Cowlitz-Wahkiakum-Skamania, Clark, West Klickitat, East Klickitat, Okanogan, Chelan-Douglas, Grant, Kittitas, Yakima, Benton-Franklin, Ferry, North Stevens, North Pend Oreille, South Stevens, South Pend Oreille, Southwest Lincoln, Central Lincoln, Spokane, Southwest Adams, Central Adams, Central Whitman, East Whitman, Walla Walla, Columbia, Garfield, and Asotin.
- (4) Outpatient operating rooms should ordinarily not be approved in planning areas where the total number of operating rooms available for both inpatient and outpatient surgery exceeds the area need.
- (5) When a need exists in planning areas for additional outpatient operating room capacity, preference shall be given to dedicated outpatient operating rooms.
- (6) An ambulatory surgical facility shall have a minimum of two operating rooms.
- (7) Ambulatory surgical facilities shall document and provide assurances of implementation of policies to provide access to individuals unable to pay consistent with charity care levels provided by hospitals affected by the proposed ambulatory surgical facility. The amount of an ambulatory surgical facility's annual revenue utilized to finance charity care shall be at least equal to or greater than the average percentage of total patient revenue, other than medicare or medicaid, that affected hospitals in the planning area utilized to provide charity care in the last available reporting year.
- (8) The need for operating rooms will be determined using the method identified in subsection (9) of this section.
- (9) Operating room need in a planning area shall be determined using the following method:
  - (a) Existing capacity.

© 2007 Thomson/West. No Claim to Orig. US Gov. Works.

WA ADC 246-310-270

WAC 246-310-270

Wash. Admin. Code 246-310-270

- (i) Assume the annual capacity of one operating room located in a hospital and not dedicated to outpatient surgery is ninety-four thousand two hundred fifty minutes. This is derived from scheduling forty-four hours per week, fifty-one weeks per year (allowing for five weekday holidays), a fifteen percent loss for preparation and clean-up time, and fifteen percent time loss to allow schedule flexibility. The resulting seventy percent productive time is comparable to the previously operating hospital commission's last definition of 'billing minutes' which is the time lapse from administration of anesthesia until surgery is completed.
- (ii) Assume the annual capacity of one operating room dedicated to ambulatory surgery is sixty-eight thousand eight hundred fifty minutes. The derivation is the same as (a)(i) of this subsection except for twenty-five percent loss for prep/clean-up time and scheduling is for a thirty-seven and one-half hour week. Divide the capacity minutes by the average minutes per outpatient surgery (see (a)(vii) of this subsection). Where survey data are unavailable, assume fifty minutes per outpatient surgery, resulting in a capacity for one thousand three hundred seventy-seven outpatient surgeries per room per year.
- (iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.
- (iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in an area. Exclude cystoscopic and other special purpose rooms (e.g., open heart surgery) and delivery rooms.

#### (b) Future need.

- (i) Project number of inpatient and outpatient surgeries performed within the hospital planning area for the third year of operation. This shall be based on the current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.
- (ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculation of (b)(iv) of this subsection.
- (iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to 'billing minutes.'
- (iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.

#### (c) Net need.

- (i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.
- (ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection

Page 3

WA ADC 246-310-270

WAC 246-310-270

Wash. Admin. Code 246-310-270

from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

Statutory Authority: RCW 70.38.135 and 70.38.919. 92-02-018 (Order 224), S 246-310-270, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as S 246-310-270, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 70.38.919. 90-16-058 (Order 073), S 248-19-700, filed 7/27/90, effective 8/27/90.

<General Materials (GM) - References, Annotations, or Tables>

WAC 246-310-270, WA ADC 246-310-270

WA ADC 246-310-270 END OF DOCUMENT

© 2007 Thomson/West. No Claim to Orig. US Gov. Works.

# **APPENDIX B**



### STATE OF WASHINGTON DEPARTMENT OF HEALTH ADJUDICATIVE SERVICE UNIT

OGDEN MURPHY WALLACE, PLLC

In the M	atter of:				
	•				
OVERLAKE HOSPITAL MEDICAL					

CENTER, a Washington non-profit corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, dba EVERGREEN HEALTHCARE, a Washington public hospital district,

Petitioners.

Docket No. 03-06-C-2001CN

FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER ON REMAND

### APPEARANCES:

Petitioner, Overlake Hospital Medical Center, by Ogden Murphy Wallace PLLC, per Donald W. Black, Attorney at Law

Petitioner, King County Public Health District No. 2, dba Evergreen Healthcare, by Livengood, Fitzgerald, & Alskog, PLLC, per James S. Fitzgerald, Attorney at Law

Intervenor, Swedish Health Services, dba Swedish Medical Center, by Bennett Bigelow & Leedom, P.S. per Stephen I. Pentz, Attorney at Law

Department of Health Certificate of Need Program, by Office of the Attorney General, per Richard A. McCartan, Assistant Attorney General

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

Following the issuance of the Amended Findings of Fact, Conclusions of Law and Final Order, Swedish Health Services (Swedish) filed a petition in King County

FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER ON REMAND

Page 1 of 19

Docket No. 03-06-C-2001CN

Superior Court appealing the order. The Superior Court remanded the matter for further action.

### ISSUES

- 1. Whether Swedish correctly included the number of surgeries performed at exempt ambulatory surgery center operating rooms in its WAC 246-310-270 calculation of the surgical procedure, use rate, and correctly excluded the number of exempt ambulatory surgery center operating rooms in its calculation of the existing operating room capacity determination?
- 2. Whether the Program's decision to grant the Swedish certificate of need application should be granted?

### SUMMARY OF THE EVIDENCE

Randall Huyck, Robin Edward MacStravic, and Jody Carona testified at the hearing. The following thirteen exhibits were admitted at the hearing:

Exhibit 1: The Swedish Certificate of Need Application Record.

Exhibit 2: Health Service Area Map showing Southeast (yellow) and East (blue) King County Service Areas.

Exhibit A: Program analysis in the Northwest Nasal Sinus Center application (Certificate of Need No. 1250).

Exhibit B: Resume of Robin Edward MacStravic, Ph.D.

Exhibit C: Deposition of Program Analyst Randy Huyck, taken August 27, 2003 (pages 58 through 95).

Exhibit D: Facsimile dated August 20, 2003, with Program work sheets used in the original analysis date of August 15, 2003.

Exhibit E: Four ambulatory surgery center need methodology worksheets prepared by Jody Carona, Health Service Planning & Development, based on the Program's worksheets and data in the record, demonstrating the numerical need:

E-1: In the Swedish defined planning area if all exempt ambulatory surgery center operating rooms are included in the available supply:

E-2: In the Swedish planning area if all surgeries performed in all exempt ambulatory surgery center operating rooms are excluded from the use rate;

E-3: In the East King County planning area if all exempt ambulatory surgery center operating rooms are included in the available supply; and

E-4: In the East King County planning area if all surgeries performed in all exempt ambulatory surgery center operating rooms are excluded from the use rate.

Exhibit F: Oversized Map of Proposed Service Area for Swedish ambulatory surgery center (Exhibit 7 from the Huyck deposition).

Exhibit G: Swedish Defined Service Area (actual Swedish defined service area facilities per Department of Health directory of certified ambulatory surgery centers and Swedish application).

Exhibit H: Summary of East King Surgery 2001 Utilization Data and Use Rate Calculations corrected Calculation of Need – Northwest Nasal Surgery Center.

Exhibit I: 2006 East King Secondary Health Service Area – Excluding Exempt Facilities.

Exhibit J: Swedish Bellevue Ambulatory Surgery Center Need Methodology:

J-1: Methodology using 102/1000 use rate.

J-2: Methodology using 82/1000 use rate.

J-3: Methodology using 57/1000 use rate.

J-4: Methodology using 76/1000 use rate.

Exhibit K: November 27, 2002 letter to Lori Aoyama, Health Facilities Planning & Development, from Randy Huyck (with attached copies of the Program's application of the ambulatory surgery center numeric need methodology contained in WAC 246-310-270:

K-1: Program methodology.

K-2: Methodology using Evergreen/Overlake number of surgeries (prepared November 27, 2002).

K-3: Methodology using Northwest Nasal Sinus Center projected surgeries (prepared November 27, 2002).

K-4: Methodology as prepared by applicant Northwest Nasal Sinus Center (prepared November 27, 2002).

K-5: East King Ambulatory Surgery Center Survey CN Facilities (prepared November 27, 2002).

K-6: East King Ambulatory Surgery Center Survey All Responding (prepared November 27, 2002).

Based on the evidence and exhibits in this matter, the Presiding Officer enters the following:

### I. FINDINGS OF FACT

## A. Background

1.1 The Certificate of Need Program (the Program) granted Swedish Health Services (Swedish) Certificate of Need No. 1264 to establish an ambulatory surgical facility in Bellevue, Washington. Overlake Hospital Medical Center and Evergreen Healthcare (the Petitioners) appealed the Program's decision. Swedish was permitted to intervene in the appeal.

- 1.2 On July 8, 2005, the Presiding Officer issued an Amended Findings of Fact, Conclusions of Law and Final Order (the Final Order). The Final Order reversed the Program's decision that granted the certificate of need to Swedish.
- 1.3 On August 9, 2005, Swedish filed a Petition for Judicial Review in King County Superior Court pursuant to RCW 34.05.530. On April 19, 2006, King County Superior Court Judge Douglas North issued an Order Reversing the Presiding Officer's Amended Findings of Fact, Conclusions of Law and Final Order, and Remanding to the Presiding Officer for Further Proceedings (the Remand Order). Judge North ruled, in relevant part:

Accordingly, the Presiding Officer's Final Order is affirmed in part and reversed in part. The case is remanded to the Presiding Officer, based on the evidence presented by the parties to the Department of Health during the application process and the adjudicative proceeding, to (i) determine whether Swedish's proposed ASC satisfies the certificate of need criteria, using the East King County planning area; and (ii) address any other issues raised by the parties in the prior adjudicative proceeding and not previously addressed in the Final Order or this order.

The Remand Order at 2.

1.4 Surgery can be performed on an inpatient or outpatient basis.<sup>1</sup> Inpatient surgery is when a person's surgery requires board and room in a health care facility (i.e., a hospital) on a continuous twenty-four-hour-a-day basis.<sup>2</sup> Therefore, outpatient surgery is when a person's surgery requires less than twenty-four hour care. When a

<sup>2</sup> See WAC 246-310-010.

<sup>&</sup>lt;sup>1</sup> "Surgery" means that "branch of medicine dealing with the manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases." Taber's Cyclopedic Medical Dictionary (14<sup>th</sup> Edition, 1981), at 1395.

need exists for additional outpatient operating room capacity, preference is given to dedicated outpatient operating rooms.<sup>3</sup>

- be performed in an ambulatory surgical facility. An "ambulatory surgical facility" is a free standing entity that operates primarily for the purpose of performing outpatient surgical procedures, that is surgery for patients who do not require hospitalization. To qualify as an ambulatory surgical facility, the facility must have a minimum of two operating rooms. The facility can be located in a private physician or dentist office. When the use of the facility is not restricted to a specific individual or group practice, the facility can qualify as an ambulatory surgical facility. When a facility's use is restricted to a specific individual or group practice, by definition, it is not an ambulatory surgical facility. These exempt facilities can be referred to as ambulatory surgical centers.
- 1.6 Characterizing a facility as an ambulatory surgical facility or an ambulatory surgical center is important under the law. An ambulatory surgical facility must obtain a certificate of need to operate in the state of Washington.<sup>8</sup> An ambulatory surgical center is exempt from the certificate of need requirement.

<sup>4</sup> WAC 246-310-010.

<sup>6</sup> See WAC 246-310-010.

<sup>&</sup>lt;sup>3</sup> WAC 246-310-270(5).

<sup>&</sup>lt;sup>5</sup> WAC 246-310-270(6) and WAC 246-310-010. To "operate" is "to perform an incision or to make a suture on the body or any of its organs or parts to restore health." Taber's Cyclopedic Medical Dictionary (Edition 14, 1981), at 990.

<sup>&</sup>lt;sup>7</sup> The term ambulatory surgical center is not defined in chapter 246-310 WAC. The term is being used to help to differentiate between exempt and non-exempt facilities.

<sup>8</sup> WAC 246-310-270(1).

- 1.7 The decision whether to grant or deny an ambulatory surgical facility certificate of need application is determined by using a mathematical formula or methodology to determine whether there is a "need" for an additional facility (that is, a requirement for additional operating room capacity). To determine whether need for an additional facility exists requires the identification of a geographic region known as a secondary health services planning area (the health planning area). If the applicant can show there is a net need for dedicated outpatient operating rooms in the relevant health planning area in the future (three years after the applicant anticipates starting the operation of the facility) the application is granted. If no need exists, the application is denied.
- Capacity speaks to the number of surgeries that can be performed in an operating room. The surgery information is obtained from information derived from surveys provided by facilities in the health planning area or by use of a default figure provided in the regulation. Facilities in a health planning area are not required to complete the surveys regarding surgical capacity at their respective facilities. Thus, the capacity calculations in any given application are affected by the number of facilities that reply to the submitted surveys.<sup>11</sup>

<sup>9</sup> WAC 246-310-270(9)

The Program analyst acknowledged at hearing that an issue exists with any use rate calculations, as the figure is calculated without receiving complete surgical statistics.

Deciding whether future operating room capacity is necessary requires the calculation of a figure known as a "use rate." The use rate means a projection of the number of inpatient and outpatient surgeries within the applicant's health planning area for the applicant's target year (the third year of operation). The projection is based on the current number of surgeries adjusted for the forecasted growth in the population served, and may be adjusted for trends in surgeries per capita (that is, surgeries according to the number of individuals). The use rate is represented by a percentage of surgeries required per each one thousand population (for example, 100 surgeries per each 1000 individuals, or 100/1000).

1.10 When calculating the use rate for a health planning area, it is necessary to include the surgical volume or number of surgeries that have been performed both in ambulatory surgical centers (that is, surgical centers that are exempt from the requirement of obtaining a certificate of need) and ambulatory surgical facilities (non-exempt facilities which are required to obtain a certificate of need). When calculating the number of existing facilities in a health service area, it is necessary to exclude from that count the number of operating rooms from ambulatory surgical centers (exempt facilities). The calculation performed under this regulation requires a comparison of separate concepts: (1) The total volume or number of inpatient and outpatient surgeries which have been performed in the planning area; and (2) the amount of capacity or facilities needed to accommodate the number of anticipated future surgeries (based on the anticipated increase in the population) in the health planning area.

<sup>12</sup> See WAC 246-310-270(9)(b)(i).

1.11 The number of anticipated future surgeries can be calculated by applying the use rate to the anticipated future population. Determining whether an individual will obtain that future surgery, in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility) cannot be reduced to a mathematical formula. The first concept (anticipated future surgeries) is a numerical value. The second concept (the location of the future surgery) cannot be determined with mathematical certainty. For example, a patient who may qualify for surgery at an exempt ambulatory surgical center in the present may not qualify for surgery in the future at the same exempt facility. Another example is a surgeon who holds surgical privileges at an exempt ambulatory surgical center in the present, may not hold surgical privileges at the same facility in future. Finally, the exempt ambulatory surgical center may no longer exist.

#### B. Need.

- 1.12 What does this mean for calculating the need methodology? It means capturing all current surgical capacity statistics from ambulatory surgical facilities (non-exempt facilities) and ambulatory surgical centers (exempt facilities) in calculating existing capacity, but calculating future need considering only ambulatory surgical facilities to ensure that the patients have access to surgical facilities in the future.
- 1.13 Swedish submitted its application to establish the free-standing ambulatory surgical facility in November 2002. Under its application, the third year of operation would be 2006. Swedish provided need calculation information as a part of its application. The Swedish information shows that with a use rate of 102/1000 (based on

National Center for Health Statistics data) and a population of 533,055 in 2004 (based on the Northwest Nasal Sinus Center application) there existed a net need for 5.9 outpatient operating rooms. PR 316–317. With a use rate of 82/100 (obtained from the Northwest Nasal Sinus Center application) and using the same 2004 population figure, there existed a net need for 1.0 outpatient operating rooms. PR 319.

- 1.14 The Swedish need calculations under WAC 246-310-270(9) included all surgery date, whether those surgeries were performed in an ambulatory surgery center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed, Swedish performed those calculations using only ambulatory surgical facility operating rooms to show the existence of a surplus or shortage of dedicated outpatient operating rooms.
- 1.15 The Program submitted need figures at hearing based on information contained in the Swedish application records. With a use rate of 82/1000 and a 2006 population figure of 546,288, there existed a net need for 5.39 dedicated outpatient operating rooms. Exhibit J-2.
- 1.16 The Program need calculations under WAC 246-310-270(9) included all surgery data, whether those surgeries were performed in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed, the Program performed those calculations using only ambulatory surgical facility operating rooms to show the existence of a surplus or shortage of dedicated outpatient rooms.

- 1.17 Information in both the Swedish application and the Program's certificate of need analysis show need exists. However, Swedish used 2004 population information as opposed to 2006 population figures (the third year of operation) as required under WAC 246-310-270(9)((b)(i). The Northwest Nasal Sinus Center use rate (82/1000) was based on state population information as opposed to national population figures from the National Center for Health Statistics (102/1000).
- 1.18 In calculating whether operating room need exists, the appropriate use rated is be 82/1000, as this figure is derived from state population information and the appropriate health planning area. The appropriate population information is the 2006 population information from the East King County health planning area. That population figure is 546,288. See Exhibit J-2. The calculations show a net need for an additional 5.39 dedicated outpatient operating rooms. Therefore, need exists.
- 1.19 All surgery data (the total number of surgeries performed) was included in the calculations in Finding of Fact 1.18 above, whether those surgeries were performed in an ambulatory surgical center (an exempt facility) or an ambulatory surgical facility (a non-exempt facility). When calculating whether need existed in Finding of Fact 1.18, calculations were performed using only ambulatory surgical facility outpatient operating rooms to show a shortage of dedicated outpatient operating rooms in the East King County health planning area.
- C. Remaining Certificate of Need Criteria.
- 1.20 Swedish provided financial information to show that the immediate and long range capital and operating costs for its proposed ambulatory surgical facility

project could be met. The Program considered whether the Swedish project was financially feasible by using a financial ratio analysis to assess the financial impact of the project on the overall facility operation. PR 563–564. The Program also compared costs of the project and determined the Swedish project would not result in an unreasonable impact on the costs and charges for health services within the service area. PR 565. Swedish provided sufficient information to show that it could finance the project from available cash reserves. PR 566.

- 1.21 Swedish provided information to show that it could meet the structure and process (quality) of care for the project. Swedish provided sufficient information in its application to show that it could meet staffing requirements, establish sufficient ancillary and support services and would conform to any applicable legal requirements.

  PR 566–568.
- 1.22 Swedish provided information in its application to show that it could meet the cost containment requirements of the project. Swedish provided information to show it had considered whether there were any superior alternatives to its proposal to establish an ambulatory surgical facility, and that the project would not have an impact on the costs and charges to the public. PR 566–568.

#### II. CONCLUSIONS OF LAW

2.1 The certificate of need program is regulated pursuant to chapter 70.38 RCW and chapter 246-310 WAC. The development of health services and resources should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation.

RCW 70.38.015(2).

- 2.2 In all license application cases, the burden shall be on the applicant to establish that the application meets all applicable criteria. WAC 246-10-606. The Program then decides whether to grant or deny a certificate of need application. The Program's written decision must contain sufficient information to support the Program's decision granting or denying the application. See WAC 246-310-200(2)(a); see also In re Auburn Regional Medical Center, Docket No. 01-05-C-1052CN (February 20, 2003). Evidence is admissible in certificate of need hearings if it is the kind of evidence on which reasonably prudent persons are accustomed to rely on in the conduct of their affairs. RCW 34.04.452; WAC 246-10-606.
- 2.3 In general a certificate of need hearing does not supplant the certificate of need application review process. Rather, the hearing assures that the procedural and substantive rights of the parties have been observed and factual record supports the Program's decision and analysis. *In re Ear, Nose, Throat*, Docket No. 00-09-C-1037CN (April 17, 2001) (Prehearing Order No. 6). While the hearing does not supplant the certificate of need review process under normal circumstances, the King Count Superior Court remanded the proceeding to the Presiding Officer in this case to determine whether the application should be granted using information contained in the application record regarding the East King County planning area. The remand order also required the Presiding Officer to address any other issues raised by the parties in the prior

Certificate of need proceedings are governed by the Administrative Procedure Act (chapter 34.05 RCW), chapter 246-310 WAC and chapter 246-08 WAC. WAC 246-310-610: The relevant sections in chapter 246-08 WAC were replaced in 1993 by chapter 246-10 WAC. WAC 246-10-101

adjudicative proceeding and not previously addressed in the Final Order or this order. See the Remand Order, page 2.

- A. First Remand Issue: Need.
- 2.4 There is sufficient information in the Swedish application file to answer the first issue identified in the Remand Order, specifically to determine whether the ambulatory surgical facility proposed by Swedish satisfied the certificate of need criteria using the East King County planning area. See Findings of Fact 1.13 through 1.18. Regarding the 2006 project year, there is need for an additional 5.39 operating rooms in the East King County planning area. See Finding of Fact 1.18.
- B. Second Remand Issue: Issue Not Previously Addressed in Earlier Final Order.
- County planning area) requires answering another issue that was not addressed in the Amended Final Order. That issue is whether, when calculating operating room need under WAC 246-310-270(9), the applicant can include the number of surgeries performed at an exempt ambulatory surgical center when determining the surgical procedure use rate, but exclude the number of operating rooms in an exempt ambulatory surgical center from the count in existing capacity. The Certificate of Need Program has historically used this approach in reviewing ambulatory surgical facility applications.
- 2.6 The rule which is applied is WAC 246-310-270. That rule provides, in pertinent part:

(9) Operating room need in a planning area shall be determined using the following method:

(a) Existing capacity.

- (iii) Calculate the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area.
- (iv) Calculate the total annual capacity (in number of minutes) of the remaining inpatient and outpatient operating rooms in the area, including dedicated specialized rooms except for twenty-four hour dedicated emergency rooms. When dedicated emergency operating rooms are excluded, emergency or minutes should also be excluded when calculating the need in the area. Exclude cystoscopic and other special purpose rooms (e.g. open heart surgery) and delivery rooms.

### (b) Future need.

- (i) Project number of inpatient and outpatient surgeries performed within the third year of operation. This shall be based on current number of surgeries adjusted for forecasted growth in the population served and may be adjusted for trends in surgeries per capita.
- (ii) Subtract the capacity of dedicated outpatient operating rooms from the forecasted number of outpatient surgeries. The difference continues into the calculations of (b)(iv) of this subsection.
- (iii) Determine the average time per inpatient and outpatient surgery in the planning area. Where data are unavailable, assume one hundred minutes per inpatient and fifty minutes per outpatient surgery. This excludes preparation and cleanup time and is comparable to "billing minutes".
- (iv) Calculate the sum of inpatient and remaining outpatient (from (b)(ii) of this subsection) operating room time needed in the third year of operation.
- (c) Net Need.

- (i) If (b)(iv) of this subsection is less than (a)(iv) of this subsection, divide their difference by ninety-four thousand two hundred fifty minutes to obtain the area's surplus of operating rooms used for both inpatient and outpatient surgery.
- (ii) If (b)(iv) of this subsection is greater than (a)(iv) of this subsection, subtract (a)(iv) of this subsection from the inpatient component of (b)(iv) of this subsection and divide by ninety-four thousand two hundred fifty minutes to obtain the area's shortage of inpatient operating rooms. Divide the outpatient component of (b)(iv) of this subsection by sixty-eight thousand eight hundred fifty to obtain the area's shortage of dedicated outpatient operating rooms.

WAC 246-310-270(9) (emphasis added).

2.7 When capturing outpatient surgery data (the number of surgeries) for use in calculating future need, all outpatient surgery data should be included in the final data figure. All outpatient surgery data means data from both exempt and non-exempt facilities. The plain language of WAC 246-310-270(9)(a)(iii) requires that operating room need shall be determined using the total annual capacity (in number of surgeries) of all dedicated outpatient operating rooms in the area. The plain language of the rule does not differentiate between exempt (ambulatory surgical centers) and non-exempt (ambulatory surgical facilities). Rules of statutory construction apply to administrative rules and regulations, particularly where they are adopted pursuant to express legislative authority. See State v. Burke, 92 Wn.2d 474, 478 (1979). Where the meaning of a provision is plain on its face, the court must give effect to that plain meaning as an expression of legislative intent. City of Olympia v. Drebick, 156 Wn.2d 289, 295 (2006) (citing Department of Ecology v. Campbell & Gwinn LLC, 146 Wn.2d 1, 9–10 (2002).

- In other words is the operating room need calculation restricted to only the number of non-exempt (ambulatory surgical facility) operating rooms, or all operating rooms consistent with the reading of WAC 246-310-270(9)(a). A reading of the regulatory language in WAC 246-310-270(9)(b) speaks to projecting the number of inpatient and outpatient surgeries performed in the planning area. This language appears to be all inclusive, similar to a reading of the capacity language set forth in WAC 246-310-270(9)(a).
- 2.9 However, the language of WAC 246-310-270(9)(b) and (c) cannot be read in isolation. A provision's plain meaning may be ascertained by an examination of the statute in which the provision at issue is found, as well as related statutes or other provisions of the same act in which the provision is found. *City of Olympia v. Drebick*, 156 Wn.2d at 295 (internal citations omitted). The legislative declaration of public policy states that health planning should promote, maintain, and assure that all citizens have accessible health services. *See* RCW 70.38.015(1). If the more inclusive approach were followed, the calculation of available operating rooms would include ambulatory surgery center (exempt) operating rooms that would not be available to many of the individuals within the health planning area. *See* Findings of Fact 1.11 and 1.12. For this reason, while all surgeries from whatever source should be included in the existing capacity calculations under WAC 246-310-270(9)(a), that inclusive approach should not

be used in determining the future need/net need calculation under WAC 246-310-270(9) (b) and (c).

#### III. ORDER

Based on the foregoing Findings of Fact and Conclusions of Law of the Amended Final Order, and the above Findings of Fact and Conclusions of Law following the King County Superior Court remand order, it is ORDERED:

- 3.1 There is a net need for 5.39 additional dedicated outpatient operating rooms in the East King County planning area in the 2006 project year.
- 3.2 Certificate of Need No. 1264 for Swedish Health Services to establish an ambulatory surgical facility in Bellevue, Washington, is GRANTED.

Dated this day of November, 2006.

JOHN F. KUNTZ, Health Law Judge

Presiding Officer

#### NOTICE TO PARTIES

Either party may file a petition for reconsideration. RCW 34.05.461(3); . RCW 34.05.470. The petition for reconsideration must be filed within 10 days of service of this Order with:

Adjudicative Service Unit P.O. Box 47879 Olympia, WA 98504-7879

And a copy must be sent to:

Certificate of Need Program P.O. Box 47852 Olympia, WA 95204-7852

FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER ON REMAND

Page 18 of 19

Docket No. 03-06-C-2001CN

The petition must state the specific grounds upon which reconsideration is requested and the relief requested. The petition for reconsideration is considered denied 20 days after the petition is filed if the Adjudicative Service Unit has not responded to the petition or served written notice of the date by which action will be taken on the petition.

A petition for judicial review must be filed and served within 30 days after service of this Order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, however, the 30-day period will begin to run upon the resolution of that petition.

This order remains in effect even if a petition for reconsideration or petition for judicial reviewed is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).

# **APPENDIX C**



January 29, 2003

Mr. Randall Huyck, Analyst Certificate of Need Program Department of Health 2725 Harrison Avenue, Suite 500 Olympia, WA 98504

Dear Mr. Huyck:

I am writing on behalf of the Commissioners of King County Public Hospital District #4 as an affected party to the application submitted by Swedish Medical Center proposing to establish an ambulatory surgery center in Bellevue.

During it's previous operation from 1994 to 1997, Snoqualmie Valley Hospital and Swedish Medical Center had a relationship, which included several members of Swedish's active surgical staff coming to Snoqualmie to perform surgery cases on a regular basis.

In 1999 and 2000, I met multiple times with representatives from Swedish including Messrs. Richard Keck, Cal Knight, and Richard Peterson, in hopes of reconstituting some type of relationship that might allow Snoqualmie Valley Hospital to reopen. They appeared quite interested at the time, particularly when the offer to lease our facility for the paltry sum of \$1.00 per year plus the in-kind value of services provided to our residents was presented. Their stated thoughts at that time were to possibly "relocate" the beds from our facility into a "new" facility located within the District but closer to Issaquah and adjacent to I-90 where it could more easily be seen. Their explanation to us was that they wished to develop a site with enough land to build a small medical campus including medical office buildings and an expandable footprint hospital. When it was determined by Swedish that there was not an acceptable/available parcel of land for that type of project between Snoqualmie and Issaquah, Mr. Peterson informed Commission Chairman Carol Hoch that Swedish was no longer interested in our facility.

It appears through anecdotal information I have received that on the "Greater Eastside" there may currently be excess capacity available at both the Evergreen and Overlake ambulatory Surgery Centers. Additionally, the future destiny and potential availability of the surgical facilities, both in and outpatient, at Group Health-Eastside are unknown.

As for Snoqualmie, we are located 16.2 miles and 17 minutes, 28 seconds (at the various posted speed limits), to the east of the proposed site. Due to the inability to thus far attract surgeons to our active medical staff, since our facility reopened in December, 2000, we currently have 100%

9575 Ethan Wade Way S.E. • P. O. Box 2021 • Snoqualmie, WA 98065• Tel (425) 831-2300 • Fax (425) 831-1994

Mr. Randall Huyck, Analyst Certificate of Need Program Department of Health January 29, 2003 Page Two

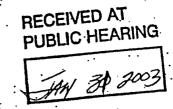
capacity for our two state licensed and approved operating suites available. These are the same two suites, the use of which we previously offered to Swedish Medical Center, an offer which was declined.

Due to the costs involved with constructing new operating suites and more unnecessary duplication of services where there currently exists considerable excess capacity, I must request in the strongest possible terms that this application be denied. If you have any questions or require any further information with regard to this matter, please do not hesitate to contact me.

Sincerely,

Jeffrey E. Lyle CHE

JEL/vrh



TEL: 206-951-1994

Snoqualmie Valley Hospital\_

January 29, 2003

Mr. Randall Huyck, Analyst Certificate of Need Program Department of Health 2725 Harrison Avenue, Suite 500 Olympia, WA 98504

Dear Mr. Huyck:

I am writing on behalf of the Commissioners of King County Public Hospital District #4 as an affected party to the application submitted by Swedish Medical Center proposing to establish an ambulatory surgery center in Bellevue.

During it's previous operation from 1994 to 1997, Snoqualmie Valley Hospital and Swedish-Medical Center had a relationship, which included several members of Swedish's active surgical staff coming to Snoqualmie to perform surgery cases on a regular basis.

In 1999 and 2000, I met multiple times with representatives from Swedish including Messrs. Richard Keck, Cal Knight, and Richard Peterson, in hopes of reconstituting some type of relationship that might allow Snoqualmie Valley Hospital to reopen. They appeared quite interested at the time, particularly when the offer to lease our facility for the paltry sum of \$1.00 per year plus the in-kind value of services provided to our residents was presented. Their stated thoughts at that time were to possibly "relocate" the beds from our facility into a "new" facility located within the District but closer to Issaquah and adjacent to I-90 where it could more easily be seen. Their explanation to us was that they wished to develop a site with enough land to build a small medical campus including medical office buildings and an expandable footprint hospital. When it was determined by Swedish that there was not an acceptable/available parcel of land for that type of project between Snoqualmie and Issaquah, Mr. Peterson informed Commission Chairman Carol Hoch that Swedish was no longer interested in our facility.

It appears through anecdotal information I have received that on the "Greater Eastside" there. may currently be excess capacity available at both the Evergreen and Overlake ambulatory Surgery Centers. Additionally, the future destiny and potential availability of the surgical facilities, both in and outpatient, at Group Health-Eastside are unknown.

As for Snoqualmie, we are located 16.2 miles and 17 minutes, 28 seconds (at the various posted speed limits), to the east of the proposed site. Due to the inability to thus far attract surgeons to our active medical staff, since our facility reopened in December, 2000, we currently have 100% Mr. Randall Huyck, Analyst Certificate of Need Program Department of Health January 29, 2003 Page Two

capacity for our two state licensed and approved operating suites available. These are the same two suites, the use of which we previously offered to Swedish Medical Center, an offer which was declined.

Due to the costs involved with constructing new operating suites and more unnecessary duplication of services where there currently exists considerable excess capacity, I must request in the strongest possible terms that this application be denied. If you have any questions or require any further information with regard to this matter, please do not hesitate to contact me.

Sincerely,

. .

**JEL/vih** 



RECEIVED AT PUBLIC HEARING

JAN 34,2003

January 30, 2002

Randy Huyck, Analyst Certificate of Need Program Department of Health P.O. Box 47852 2725 Harrison Avenue, Suite 500 Olympia, WA 98504

Dear Mr. Huyck:

Overlake Surgery Center, LLC has previously requested interested party status on the application of Swedish Health Services to establish an Ambulatory Surgery Center in Bellevue. With this letter, we request that this status be converted to affected party status, and that we be informed of the department's decision.

Overlake Surgery Center is a joint venture of Overlake Hospital Medical Center and East King-County surgeons and anesthesiologists. We received certificate of need approval in 1999 to operate a five room ambulatory surgery center, and opened in September of 2000. We have had the opportunity to review both the Swedish application and the opposition letter of Overlake Hospital Medical Center, which raises five concerns with the application. These concerns, which we concur with, include:

- When the ASC projection methodology, which is detailed in WAC, is applied correctly, no need for additional capacity exists in East King County.
- The proposal fails to demonstrate any improvement in access or availability.
- The proposal fails to demonstrate any improvement in cost or charge structure to patients or payers.
- The proposed model of care fragments quality and continuity.

00245

Telephone (425) 709-2500

 Because of a lack of demonstrable need, the proposal is clearly not the best available alternative, rendering it inconsistent with the cost containment criteria contained in WAC.

Accordingly, we believe that the Department will determine, as we have, that Swedish proposal is not needed and represents a costly duplication of existing resources.

Sincerely,

Michael Sailer, MD

President,

Board of Managers

E0/4E/K)

# OPPOSITION TESTIMONY TO SWEDISH HOSPITAL CON APPLICATION-

## OVERLAKE SURGERY CENTER, LLC

Good afternoon. I am Michael Sailer, MD, President of the Board of Managers of Overlake Surgery Center LLC, located in Bellevue. Overlake Surgery Center, a joint venture of Overlake Hospital Medical Center, local surgeons and anesthesiologists, received State certificate of need approval in 1999 to operate a five room ambulatory surgery center. We first opened our doors in September of 2000. Similar to what Swedish is proposing, we planned and "phased in" our five rooms. During the first year, only three rooms were operational. Just very recently, we made the decision to open our fifth and final room. This room is scheduled to open in May. Our current hours of operation vary depending upon patient needs, but most typically we are open 10 to 12 hours per day, 5 days per week. We have the capacity to expand those hours. Including the capacity of the fifth room, our occupancy is 56%. Overlake Surgery Center finds the Swedish application lacking sufficient information to determine its conformance with various CON requirements, including but not limited to structure and process, quality of care, and cost containment. We also note that with the recent expansion of the Evergreen Surgery Center and State approval of the Northwest Nasal Sinus Center ASC in Kirkland that no need exists for any additional capacity. We also are aware of a 2-3 room non-CON required ASC currently under construction in the affected area.

In addition to a lack of need, we have several concerns with the Swedish proposal. First, the application provides no information regarding the number and specialty of physicians that are expected to utilize the ASC. In the absence of this data, the volume and mix of

cases cannot be confirmed; but more importantly neither can quality or continuity. Ambulatory surgery patients can and do experience post-operative complications, typically at 24-48 hours post surgery. Many of the types of procedures listed in the application are complex outpatient procedures requiring close post-operative observation and follow-up potentially inappropriate for the freestanding setting. Swedish should be requested to confirm the availability and commitment of surgeons and anesthesiologists to use the proposed Bellevue facility. Additionally, Swedish should be requested to confirm the pre-surgical consultation and post-surgical availability of surgeons to support patients on the Eastside. This availability is key to success—both of the ambulatory surgery center; but more importantly to patient satisfaction and outcomes. If patients will be required to travel downtown for the pre and post-surgical activity (as well as for any post-surgical complications), then quality is diminished and costs are increased. Many post-op patients in need of emergency post-op care will present at the nearest Eastside hospital at which their Swedish surgeon will not have privileges.

Speaking of costs, we have compared as best we can, the types of cases that Swedish is proposing to serve to our existing experience. The Swedish proposal's average reimbursement per case is expected to be, at minimum, 37% higher than ours. Because Swedish's proposal appears to be hospital-based, it will be able to bill and be paid separately for various ancillary services. As a freestanding provider, we bill for and collect a single global payment that covers all services rendered.

In summary, there is no demonstrated need for this project. More than sufficient mixed use and dedicated outpatient capacity exists on the Eastside to support projected demand for the foreseeable future. We have significant questions about the medical staffing and coverage for the Swedish project. These concerns correlate directly with quality, continuity and outcomes. Given these concerns, and the higher costs that Swedish proposes, we urge the State to deny their request.

Thank you.



# **SWEDISH MEDICAL CENTER**

RECEIVED AT PUBLIC HEARING

747 Broadway Seattle, WA 98122-4307 (205) 386-6000

January 31, 2003

Randall Huyck, Analyst Certificate of Need Program Department of Health P. O. Box 47852 Olympia, WA 98504-7852

Re: Swedish Ambulatory Surgical Center - Eastside

Dear Mr. Huyck:

My name is Jowee Foutz. I am the Nurse Manager at Swedish's Same Day Surgery, First Hill campus. I have worked in an Operating Room environment for over twenty years. One of the exciting changes I have seen in the surgical setting is the definitive trend towards outpatient surgery. Ambulatory surgery appeals to the patient and family because there are fewer disruptions of normal daily activities, less separation from family, less time away from the workplace, and less worry about financial outlays.

Since I've been at Swedish, patients and families have been extremely satisfied with the care they have received. The most frequent suggestion that we consistently receive from patients is that they wished Swedish had a facility that was more accessible, convenient, and closer to their home. Swedish's proposed project to open up an Eastside Ambulatory Surgical Facility would fulfill this wish.

The clearest advantages of opening an ambulatory surgery facility along the I-90 corridor are two-fold. The first is convenience and easy access. Because we have strong, significant positive "brand" awareness in the community, Eastside residents would choose to come to our outpatient surgery to avoid the stress of fighting the ever-increasing traffic congestion along I-405 and bridges across Lake Washington. The improved access and being closer to home is a strong incentive in using our ambulatory surgical facility.

The second advantage is Swedish's reputation for quality patient care. Opening an Eastside Outpatient Surgery would allow us to extend our mission in improving the health and well being of each person we serve. In this case, to better serve our patients who reside on the Eastside. According to the CHARS database for 2001, Swedish performed over 4,000 ambulatory surgeries on patients living on the Eastside. So, why not respond to the need and bring the Swedish excellence closer to our customer's home?

I support Swedish's proposal for Eastside Ambulatory Surgical Facility. Our Eastside residents would not only have the assurance that they will be receiving unsurpassed patient care from a hospital they already trust, but it would provide them a healthcare service that has easier access and convenience making their surgical experience less anxious and more satisfying.

Sincerely, Jowee y. Jewes, Rd

Jowee Y. Foutz, RN MAOM CNOR Clinical Manager, Same Day Surgery



1035 116th Avenue NE Bellevue, WA 98004 (425) 688-5000 www.overlakehospital.org

January 28, 2003

Randy Huyck, Analyst Certificate of Need Program Department of Health P.O. Box 47852 2725 Harrison Avenue, Suite 500 Olympia, WA 98504

Dear Mr. Huyck:

Overlake Hospital Medical Center (Overlake) is an affected party to the certificate of need application of Swedish Health Services (Swedish) to establish a five room Ambulatory Surgery Center (ASC) in Bellevue, East King County. We have reviewed the materials submitted by Swedish and conclude, based on the information contained in the record, that the project fails to demonstrate compliance with applicable certificate of need criteria and therefore must be denied. Most notably, and in order to document a mathematical need for additional capacity, Swedish has outlined a planning area and presented use rate data that significantly understates the capacity of ORs currently available in East King County. When the correct planning area, use rate and OR capacity are incorporated, no need exists.

Recently, and as a result of a 2001 adjudicative proceeding, the Department of Health (DOH) was required to revisit its historical interpretation of the ASC methodology contained in WAC. In November of 2002, the DOH issued a remanded decision on the certificate of need under appeal. In the remanded decision, the DOH stated, consistent with WAC, that new ORs can only be approved in planning areas in which need is determined to exist. Because surplus capacity exists in East King and because the proposal fails to demonstrate any improvement in access, availability or cost and charge structure, it is inconsistent with WAC and must be denied.

The Swedish proposal also lacks conformance to the structure and process and cost containment criteria found in WAC 246-310. Swedish has not provided any information regarding the physicians that it assumes will use the facility. If these physicians are Seattle/Swedish based and travel over the bridges only on those days wherein they are scheduled to perform cases, any complications in the first 24-48 hours post-surgery will

presumably require that the patient travel to Seattle. Such an arrangement hinders quality of care, and actually adds to the cost of the care. Historically, the DOH has required disclosure of the physicians that propose to utilize the ASC. Such disclosure is pivotal to determining whether or not the Swedish project is viable, what its impact will be on existing providers, and most importantly what standards it will need to employ to ensure quality and continuity. The application also contains several statements and utilization/volume assumptions that cause us to conclude that the ASC is intended to be hospital-based. However, we note that the financials do not appear to include any allocation of hospital overhead even though the cost and charge structure is more similar to a hospital-based ASC than to a freestanding ASC. Clearly, at this point in time there are simply too many unanswered questions associated with the operation and utilization of this project for it to be acted upon favorably by the DOH.

Finally, Swedish's proposal is similar in many ways to the national debate raging over "boutique" providers—providers entering the market serving only one, assumedly profitable, service line. When a boutique provider enters a market, it typically does so with a limited range of services. This allows the boutique provider to "skim" the more profitable services without a concomitant requirement to provide emergency and other community-benefit services, which typically do not cover their costs of operation. At a time of great financial uncertainty in the health care market and when no need exists, a "niche" or boutique player should not be approved because of the potential adverse impact on existing community based providers and therefore on the community at large. RCW 70:38.015 declares it to be the public policy of the State of Washington:

(2) that the development of health services and resources, including the construction, modernization and conversion of health care facilities, should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation

The Swedish proposal finds itself with the insurmountable problem of a lack of demonstrated need for additional ORs. This lack of need defacto renders the Swedish project inconsistent with RCW. The attached document provides our detailed analysis of the problems inherent in the application.

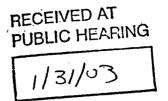
As always, Overlake appreciates the opportunity to provide comment in regard to East King County health care issues.

Sincerely,

Kenneth D. Graham.

President and Chief Executive Officer

Ken Craham



# OVERLAKE HOSPITAL MEDICAL CENTER OPPOSITION TO THE PROPOSAL OF SWEDISH HEALTH SERVICES TO ESTABLISH AN AMBULATORY SURGERY CENTER IN BELLEVUE, EAST KING COUNTY

January 2003

In reviewing the public record on the Swedish proposal to establish an ambulatory surgery center in Bellevue, Overlake has identified numerous problems that render the project out of compliance with applicable criteria contained in WAC 246-310. Specific problems within the Swedish proposal include:

- In calculating need, Swedish did not use the methodology contained in WAC 246-310-270. Only by incorrectly incorporating key variables was Swedish able to produce a mathematical need for additional capacity. When the variables are applied consistent with the requirements of WAC, (and when the methodology is applied consistent with a recent administrative law judge's ruling) no need exists in East King County. Based on a correct application of the methodology, there is a surplus of nearly four (4) inpatient or mixed use operating rooms.
- The proposal fails to demonstrate any improvement in access or availability.
- The proposal fails to demonstrate any improvement in cost or charge structure to patients or payers. It also contains conflicting assumptions regarding its certification and reimbursement (hospital-based or freestanding). As a result, its financial feasibility cannot be determined.
- The proposed model of care fragments quality and continuity and therefore lacks conformance to the structure and process criteria found in WAC 246-310-230.
- Because of a lack of demonstrable need, the proposal is clearly not the best available alternative, rendering it inconsistent with the cost containment criteria contained in WAC 246-310-240.

Each issue is discussed in detail, below.

In calculating need, Swedish did not use the methodology contained in WAC 246-310-270. Only by incorrectly incorporating key variables was Swedish able to produce a mathematical need for additional capacity. When the variables are applied consistent with the requirements of WAC, (and when the methodology is applied consistent with a recent administrative law judge's ruling) no need exists in East King County. Based on a correct application of the methodology, there is a surplus of nearly four (4) inpatient or mixed use operating rooms.

WAC 246-310-200(1) provides in pertinent part that "the findings of the department's review of certificate of need applications and the action of the secretary's designee on such applications shall... be based on determinations as to (a) whether the proposed project is needed." WAC 246-310-270 requires that operating room need be determined using a method, which in summary calculates:

- 1) a planning area specific use rate (based on historical data),
- 2) the capacity of existing providers in the planning area
- 3) future need for residents of the planning area, and
- 4) net need for additional capacity, subtracting future need (#3) from current capacity (#2).

Swedish did not employ the method as required by WAC, but rather attempted to influence the projection of "need" by:

- Creating its own planning area definition
- using a national, non-market share adjusted use rate
- significantly understating the capacity of ORs currently available

Any of these three adjustments on its own would serve to overstate net need; when combined, the three adjustments result in an exaggerated and clearly erroneous conclusion. When corrected and aligned with the requirements of WAC, no need exists in East King County.

#### Swedish "carved out" a planning area inconsistent with WAC:

Swedish defined a planning area for its project which incorporates significant portions of East and Southeast King Counties—yet excludes every zip code that contains OR capacity in these two planning areas, with the exception of Bellevue. Aside from being illogical, the applicant's service area is inconsistent with the definition in WAC, which states:

... The area to be used to plan for operating rooms and ambulatory surgical facilities is the secondary health services planning area.

(3) Secondary health services planning areas are: San Juan, Whatcom, East Skagit, Whidbey-Fidalgo, Western North Olympic, East Clallam, East Jefferson, North Snohomish, Central Snohomish, East Snohomish, Southwest Snohomish, Kitsap, North King, East King, [emphasis added] Central King, Southwest King, Southeast King, ...."

Accordingly, the projections of future need must be recalculated using East King as the planning area.

#### Swedish has utilized an inflated use rate:

The application referenced and incorporated the National Center for Health Statistics (NCHS) use rate of 102 cases per 1,000 population. This use rate is misleading for numerous reasons including:

- It is based on national data, and historically Washington State has had one of the lowest use rates of any region in the Country.
- It incorporates surgical procedures performed in all settings (physicians offices, hospitals, endoscopy centers, ASC, etc.)
- It is not market share adjusted—in other words, it assumes that 100% of the people in a given service area stay in that service area for surgery.

In its recent East King County ASC analysis and decision (dated November 4, 2002 for Northwest Nasal Sinus Center) the DOH states:

The methodology provides a basis for comparison of existing capacity for both outpatient and inpatient ORs in the planning area using current utilization of existing providers. (emphasis added).

Table 1
East King County
OR Room Supply and Case Mix, 2002

Facility	No. of Outpatient Rooms	No. of Mixed Use Rooms	Total Rooms	2002 Inpatient Surgeries	2002 Outpatient Surgeries	2002 Total Surgeries	Outpatient Surgeries as a % of Total
Overlake Hospital Medical Center	4	9	13	5,757	7,984	13,741	57.5%
Evergreen Hospital Medical Center	0.	8	8	2,701	4,138	6,839	60.5%
Evergreen Surgical Center	9	0	9	0	4,868	4,868	100.0%
Snoqualmie Valley Hospital	0	2	2	0	0	0	0.0%
Overlake Surgery Center, LLC	5	0	5	0	4,580	4,580	100.0%
Northwest Nasal ASC <sup>2</sup>	2	0	2	0	201	201	100.0%
Total	20	19	39	8,458	21,771	30,229	72.0%

Overlake is aware that a decision of the DOH to award an ASC CN in Southeast King County has been under appeal since 2000<sup>3</sup>. In that appeal<sup>4</sup>, and on April 17, 2001, the Administrative Law Judge ruled:

<sup>3</sup> Auburn Regional Medical Center's appeal of ENT Plastic Surgery Associates certificate of need.

<sup>4</sup> Prehearing order No 6, order on motion for partial summary judgment

<sup>&</sup>lt;sup>2</sup> Source: Northwest Nasal Certificate of Need application. Volumes were held to 2001 levels as certificate of need approval was not received until 11/4/02.

The use rate contained in this decision is 82 surgeries per 1,000 population; which was the rate provided by the applicant. This rate is 24% lower than the use rate contained in the Swedish application. This use rate more accurately reflects patterns in East King—however, it is potentially overstated as well because it contains the utilization of all of the operating rooms in operation in East King—and the DOH excludes many of the rooms because:

The use of these ASCs is restricted to use by only the members of the practice or group practice. These types of ASCs do not meet the definition of an ASC for Certificate of Need purposes are therefore are not counted in the available supply.\(^1\)

If the ORs are to be excluded from the count of supply, then the surgeries being performed in the rooms must be excluded from the use rate calculation—if not, need will be significantly overstated. The use rate excluding the activity occurring in the exempt ASCs is approximately 58 surgeries per 1,000. In other words, if the use rate of 82 cases per 1,000 is to be used, then the capacity must be increased to include all of the rooms located in East King that are restricted to use by only the members of a practice or group. If the DOH chooses to exclude these rooms, then the use rate of 58 cases per 1,000 is the correct rate to be employed.

# Swedish has understated the current supply of ORs:

Because the applicant did not utilize the secondary health service area of East King County, the capacity that it identified is seriously understated. Actual operating room supply in East King is 20 dedicated outpatient rooms and 19 mixed use (or inpatient) rooms for a total of 39 rooms. As Table 1 demonstrates, nearly three-quarters of all surgeries performed in East King facilities are outpatient. The data in this table was compiled from past certificate of need analyses by the DOH and actual 2002 utilization data from Overlake Hospital Medical Center, Overlake Surgery Center, Evergreen Surgery Center and Evergreen Hospital Medical Center.

DOH decision, ENT Plastic Surgery Associates, November 12, 2002, pg 4.

In this case, the Program granted certificate of need No.1212. In so doing, it relied upon its Analysis, which it now concedes is erroneous<sup>5</sup>. ...given that the program concedes that its Analysis is erroneous, the Presiding officer concludes that a remand to the program for an amended analysis of ENT's application is required by the regulatory scheme adopted by the Program and the Department. As noted above, WAC 246-310-200(1) mandates that the "findings of the department's review of certificate of need applications...shall...be based on determination as to...whether the proposed project is needed"

On November 12, 2002, the DOH reissued its decision and noted.....

The department estimates OR need in a planning area using a multi-step methodology defined in WAC 246-310-270(9). This methodology initially determines existing capacity of dedicated outpatient and mixed-use operating rooms in the planning area, subtracts this capacity from the forecast number of surgeries to be expected in the planning area in the target year, and examines the difference to determine a) whether a surplus or shortage of ORs is predicted to exist in the target year, and b) if a shortage of ORs is predicted, the shortage of dedicated and outpatient and mixed use rooms are calculated.

the methodology assumes that until the inpatient surgery capacity exceeds the total inpatient OR capacity, any additional outpatient surgeries can be done in the mixed use ORs.

When the methodology is run for East King using actual utilization and supply, a surplus of nearly four (4) inpatient or mixed use capacity exists. Therefore, while the Swedish proposal may be justified for its own business modeling, there is no identified community need, and the project must be denied.

<sup>5&</sup>quot;The program acknowledges that, in the Analysis, it did not completely work through the WAC 246-310-270(9) calculation" Certificate of Need Program's Memorandum opposing ARMC's Motion for Partial Summary Judgment, April 20, 2001, page 2.

Issue #2: The Swedish proposal fails to demonstrate any improvement in access or availability.

The application puts forth no data nor does it claim that there are access problems and/or that its project would advance access and availability to residents of East King County. To the contrary, there are 39 rooms operating in East King County that average 43% capacity. Presumably, the Swedish ASC will be open 5 days a week, during normal business hours. Given that Swedish has not documented any issues related to access and availability of existing capacity, the proposed project is not eligible for any special consideration under WAC 246-310-270.

Issue #3: The proposal fails to demonstrate any improvement in cost or charge structure to patients or payers. It also contains conflicting assumptions regarding its certification and reimbursement (hospital-based or freestanding). As a result, its financial feasibility cannot be determined.

From the information contained in the application, it is not clear whether the Swedish ASC intends to be hospital-based or freestanding. This status must be clarified as it affects both the volume of cases that can be performed and the reimbursement for the cases. Several of the ICD-9 codes that Swedish proposes will be served are largely restricted under Medicare to hospital-based programs. However, while Swedish's cost and revenue structure appears to be aligned with a hospital-based program, its pro forma does not include any hospital overhead.

Overlake has compared the Swedish per case charges, net revenues, expenses and net income to both our own outpatient surgery service and to the Overlake Surgery Center LLC. As depicted in the following table, on a per case basis, the Swedish ASC is projected to have higher charges and net revenues—meaning it will be more expensive that the current Bellevue-based outpatient surgery options.

<sup>&</sup>lt;sup>6</sup> Capacity was calculated based upon the reported hours of operation contained in the surveys submitted to the Department of Health during the certificate of need review process for Northwest Nasal Sinus Center, 2002. specific detail regarding the calculations can be found in Attachment 2.

Table 2
Comparison of Selected Variables

·	Swedish Yr 1	Swedish Year 5	Overlake Surgery Center LLC <sup>78</sup> (OSC)	Percent Difference between OSC and Swedish Year 5	Overlake Hospital Outpatient Surgery <sup>9</sup> (OHMC OS)	Percent Difference between OHMC OS and Swedish Year 5
Charges	4,413	4,469	2,896	54.3%	2,207	102.5%
Net Revenue	1,869	1,890 <sup>-</sup>	1,376	37.4%	1,192	58.6%
Salaries & Benefits	605	477	376	26.9%	371	28.6%
Supplies	410	416	187	122.5%	-145	186.9%
Total Expenses w/o Depr & Rent	1,383	1,214	755	60.8%	1,043	16.4%
Contribution Margin	486	677	621	9.0%	148	357.4%
Depreciation	475	280	51	449.0%	19	168.4%
Rent Expense	301	134	70	91.4%	-	N/A
Net Income	(290)	263	499	(47.3%)	130	102.3%

In conclusion, the Swedish proposal is more costly than existing freestanding or hospital-based alternatives.

Issue #4: The proposed model of care fragments quality and continuity and therefore lacks conformance to the structure and process criteria found in WAC 246-310-230

The application does not provide any information on the number and type (specialty) of surgeons that are expected to utilize the ASC. In the absence of this data, the volume and mix of cases cannot be confirmed; but more importantly neither can the quality or continuity. Ambulatory surgery patients can and do experience post-operative complications, typically at 24-48 hours post surgery. Many of the types of procedures

<sup>9</sup> Ibid.

<sup>&#</sup>x27; 2003 budget.

<sup>&</sup>lt;sup>8</sup> Includes special procedures including pain management.

listed in the application are complex outpatient procedures requiring close post operative observation and follow-up. Swedish should be requested to confirm the availability and commitment of surgeons and anesthesiologists to use the proposed Bellevue facility. Additionally, Swedish should be requested to confirm the pre-surgical consultation and post-surgical availability of surgeons to support patients on the Eastside. If patients will need to travel downtown for the pre and post-surgical activity (as well as for any post-surgical complications), then quality is diminished and costs are increased.

Issue #5: Because of a lack of demonstrable need, the proposal is clearly not the best available alternative, rendering it inconsistent with the cost containment criteria contained in WAC 246-310-240

WAC 246-310-240 requires that a project be "the best available alternative". Given the documented surplus, the Swedish proposal simply cannot conform to this requirement. Additionally, and as noted in Issue #4 above, the Swedish ASC is a more costly alternative (charges and net revenue per case) then are the existing outpatient facilities in East King County.

Swedish's proposal contains is similar in many ways to the national debate raging over "boutique" providers—providers entering the market serving only one, assumedly profitable service line. When a boutique provider enters a market, it typically does so with a limited range of services, which allows it to "skim" the more profitable services, without a concomitant requirement to provide emergency and other community services, which do not cover their costs of operation. At a time of great financial uncertainty in the health care market and when no need exists, a "niche" or boutique player should not be approved because of its potential adverse impact on existing community based providers. RCW 70.38.015 declares it to be the public policy of the State of Washington.

(2) that the development of health services and resources, including the construction, modernization and conversion of health care facilities, should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation

Because no need exists, the Swedish proposal is defacto inconsistent with RCW.

ATTACHMENT 1

RECALCULATION OF NEED

PER WAC 246-310-270(9)

## EAST KING COUNTY ANALYSIS OF NEED FOR ADDITIONAL OUTPATIENT OPERATING ROOM CAPACITY PER WAC 246-310-270

Service Area Definition: The Swedish ASC will be geographically sited in East King County. Therefore, the planning area is East King.

The first step in the methodology is to determine the number of ORs in the service area. Table 1 below lists the facilities and number of operating rooms by type. Please note that consistent with the definition in WAC 246-310-010, any facility whose use is restricted to only the members of a practice or group is not counted in the available supply.

## **Current Operating Room Supply**

Table 3 OR Room Supply, 2002

Facility	No. of Outpatient Rooms	No. of Mixed Use Rooms	Total Rooms
Evergreen Hospital Medical Center	0	8	8
Evergreen Surgical Center	9	0	9
Northwest Nasal ASC <sup>10</sup>	2	0	2
Overlake Hospital Medical Center	4	9	13
Overlake Surgery Center, LLC''	5	0	5
Snoqualmie Valley Hospital	0	2	2
Total	20	19	39

11 Please note that Overlake Surgery Center, LLC is in the process of operationalizing a 5th OR.

<sup>&</sup>lt;sup>10</sup> Source: Northwest Nasal Certificate of Need application. Volumes were held to 2001 levels as certificate of need approval was not received until 11/4/02.

## Surgical Volumes.

The following chart details, for 2002, actual surgical volumes of East King providers<sup>12</sup>.

Table 4
2002 Surgical Volumes East King County

Facility	Total Cases	Outpatient Cases	% Cases Outpatient	
Evergreen Hospital Medical Center	6,839	4,138	61%	
Evergreen Surgical Center	4,868	4,868	100%	
Northwest Nasal ASC	201	201	100%	
Overlake Hospital Medical Center	13,741	7,984	58%	
Snoqualmie Valley Hospital	0	0	0%	
Total	30,229	21,771	. 72%	

The next step in the methodology is to determine the planning area's use rate per 1,000 population. Utilizing the data in Table 2 above, the following use rate can be calculated.:

2002 East King Population	523,38213
2002 Surgeries	30,229
2002 Use rate	57.76

Once the use rate has been determined, the next step is to calculate the percentage of inpatient and outpatient surgeries. For the East King planning area this information is detailed in Table 5 below:

<sup>13</sup> Source: Claritas, 2002.

<sup>&</sup>lt;sup>12</sup> Source: 2002 data provided by Overlake Hospital Medical Center, Overlake Surgery Center, LLC, Evergreen Hospital Medical Center, and Evergreen Surgery Center. Data for Northwest Nasal is for 2001.

Table 5
Percent of Inpatient Versus Outpatient Surgeries by Facility, 2002

	`				
Facilities	2002 Inpatient Surgeries	Percent of Total	2002 Outpatient Surgeries	Percent of Total	2002 Total Surgeries
Evergreen Hospital Medical Center	2,701	39%	4,138	61%	6,839
Evergreen Surgical Center	0	0%	4,868	100%	4,868
Northwest Nasal ASC	0	0%	201	100%	201
Overlake Hospital Medical Center	5,757	42%	7,984	58%	13,741
Overlake Surgery Center, LLC	0	0%	4,580	100%	4,580
Snoqualmie Valley Hospital	. 0	0%	0	0%	0
Total	8,458	28%	21,771	72%	30,229

Table 6 below, details the average number of minutes for both inpatient and outpatient surgeries.

Table 6
Average Minutes Per Case by Type

Facility	Total Inpatient	Total Inpatient			Outpatient	Inpatient
	Minutes	Cases	Minutes/	Minutes	Cases	Minutes/
			Case			Case
Evergreen Hospital	367,941	2,701	136	307,997	4,238	73
Medical Center		•				
Evergreen Surgical	0	0	. 0	249,895	4,868	51
Center					·	
Northwest Nasal	. 0	0	. 0	18,900	201	94
ASC						
Overlake Hospital	944,07614	5,757	164	569,088 <sup>15</sup>	7,984	71
Medical Center						
Overlake Surgery	0	0	0	277,756	4,580	61
Center, LLC						
Snoqualmie Valley	0	0	0	. 0	0	50
Hospital						
Total	1,312,017	8,458	155	1,423,636	21,871	65

The following table, Table 7, details the application of the methodology<sup>16</sup>. Consistent with that application, the inpatient surgery capacity can accommodate the unmet outpatient surgery need and results in a surplus of inpatient surgery capacity. Therefore, this project does not meet the requirements of WAC 246-310-270(9) nor WAC 246-310-210 (Need) and must be denied.

15 Source: Annualized based upon 9 months of data.

<sup>&</sup>lt;sup>14</sup> Annualized based upon 9 months of data.

<sup>&</sup>lt;sup>16</sup> Table 7 is an application of the methodology contained in WAC and is a replication of Table 9 in the remanded analysis, dated November 12, 2002, for ENT Plastic Surgery Associates.

94,250 minutes/year/mixed-use OR

68,850 minutes/year/mixed-use OR dedicated outpatient OR a.ii.

20 dedicated outpatient OR's x 68,850 minutes = 1,377,000 minutes dedicated OR capacity 21,185 outpatient surgeries a.iii

19 mixed-use OR's x 94,250 minutes = 1,790,750 minutes mixed use OR capacity 1,553 mixed use surgeries a.iv

Projected outpatient surgeries = 22,469 = 1,303,201 minutes outpatient surgeries Projected inpatient surgeries = 8,738 = 1,354,383 minutes inpatient surgeries b.i.

Forecast # of outpatient surgeries - capacity of dedicated outpatient ORs 22,469-21,185 = 1,284 outpatient surgeries b.ii.

Average time of outpatient surgeries Average time of inpatient surgeries b.iii.

155 minutes

65 minutes

remaining outpatient surgeries (b.ii.) x average time = 83,487 remaining outpatient surgery minutes needed inpatient surgeries x average time of inpatient surgeries = 1,354,383 inpatient surgery minutes needed b.iv.

Total Minutes = 1,437,871 minutes

if b.iv. < a.iv., divide (inpatient part of b.iv.-a.iv.) by 94,250 to determine shortage of inpatient OR's

,790,750 -1,437,871 = 3.74 surplus of mixed use operating rooms

352,879/94,250

# ATTACHMENT 2 CALCULATION OF CAPACITY

Facility	No. of Outpatient Rooms	No. of Mixed Use Rooms	Total Rooms	Hours of Operation	Minutes/ Year (capacity) <sup>17</sup>	Total Minutes (actual 2002)	Occups
Overlake Hospital Medical Center	4	9	13	550 hours/week (IP) 180 hours/week (OP) <sup>18</sup>	2,277,600	1,513,164	66.4%
Evergreen Hospital Medical Center	0	8	8	79 hours/week	1,896,000	675,938	35.7%
Evergreen Surgical Center	9	0	8	210 hours/week	630,000	249,895	39.7%
Snoqualmie Valley Hospital	0	2	0	WAC 246- 310-270 (9)	188,500	0	0.0%
Overlake Surgery Center, LLC	5	0	5	50 hours/week	1,200,000	277,756	23.1%
Northwest Nasal ASC <sup>19</sup>	0	2	2	24 hours/week	144,000	18,900	13.1%
Total	20	19	39		6,336,100	2,735,653	43.2%

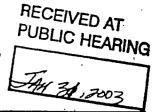
Weeks operated per year were assumed to be 50 unless otherwise stated.

18 Assumed that these were total hours for all rooms.

19 Source: Northwest Nasal Certificate of Need application. Volumes were held to 2001 levels as certificate of need approval was not received until 11/4/02.

## Drs. 1-20orhead, Ombrellaro & Associates, L.L.P.

Vascular, General and Thoracic Surgery • Eastside Vascular Lab 1135 - 116<sup>th</sup> Ave, N.E., Suite 220 / Bellevue, WA 98004 Tel: (425) 450-7007 / Fax: (425) 450-0026



Randall Huyck, Analyst Certificate of Need Program Department of Health P. O. Box 47852 Olympia, WA 98504-7852

January 28, 2003

Dear Department of Health Officials,

On behalf of the surgeons at Overlake Hospital Medical Center, I would like to voice our opposition to Swedish Medical Center's Certificate of Need proposal to establish an Ambulatory Surgery Center in Bellevue. We do not believe it is in the best interest of the Eastside community for the following reasons:

- ✓ The State of Washington has a methodology, outlined in administrative code that it must use to project the need for outpatient operating rooms. When this methodology is applied accurately, there is a surplus of operating rooms in East King County. As such, there is no need for the Swedish ASC. In fact, it proposes an unnecessary duplication and a dilution of current costly resources.
- ✓ The Swedish proposal proposes no unique services and no improvement in access or cost, it will only offer services that are already available and accessible to Eastside residents.
- ✓ Service quality concerns: to the extent that the Swedish ASC surgeons offices are in Seattle, any cases that produce complications in the first 24-48 hours after discharge would presumably require the patient either to travel to Seattle for care or be seen on an emergent basic at one of the local hospitals by surgeons not involved in the case. This is not optimal patient care.
- ✓ Each of the local East King County hospitals has an extensive commitment to meeting the healthcare need of the East King Community. Swedish does not. Overlake Hospital has a 40+ year history of providing comprehensive services to community residents and serves over 41,000 people a year in its Emergency Room. Overlake Hospital's commitment to the community includes more than \$2.2 million it provides annually in charity care. It also includes the education classes and community events it sponsors. In 2002, Overlake provided more than \$1,000,000 in

## Drs. Moorhead, Ombrellaro & Associates, L.L.P.

Vascular, General and Thoracic Surgery • Eastside Vascular Lab 1135 - 116<sup>th</sup> Ave, N.E., Suite 220 / Bellevue, WA 98004 Tel: (425) 450-7007 / Fax: (425) 450-0026

community health programming and health research, including car seat safety checks, stroke screening, skin cancer screening, exercise classes for cancer patients, various support groups, a medical library, and various residency programs (pharmacy, radiology and ultrasound). Many of Overlake's employees also live locally and are active and contributing members of the community.

✓ Swedish's proposal closely resembles the "boutique" and specialty facilities that have received national attention over the past several years. The reality is that these boutique facilities "skim off" profitable service lines; leaving the less profitable business for the community hospital. The consequence is that the local community hospital is left with fewer resources to provide the 24/7 full service access the community needs, and far fewer resources to provide outreach and community health programming.

Sincerely,

Mark Ombrellaro MD

Chief of Surgery

Overlake Hospital Medical Center



## SPECIALTY EYECARÈ CENTRE

The accent is on care

Laser, Microsurgery. Cataract & Glaucoma Consultation

HOWARD S. BARNEBEY, M.D.



29 January 2003

Randall Huyck, Analyst Certificate of Need Program Department of Health P.O. Box 47852 Olympia, WA 98504-7852

Re: Swedish Ambulatory Surgical Center - Eastside

RECEIVED AT PUBLIC HEARING

Dear Mr. Huyck:

I am an ophthalmologist with practices in both the Seattle and Bellevue area and am writing to support Swedish Hospital's proposal for a Certificate of Need to develop an ambulatory surgical center in the Factoria area south of Bellevue along the I-90 corridor.

A considerable number of my patients are referred from outlying areas for surgical care. An increasing percentage come from the Eastside and there has been some reluctance, in spite of the excellent care at Swedish Hospital, to make the trip across the bridge for surgery. There is no question that some of my patients find it more convenient to have their surgery done at a facility on the Eastside and that I occasionally will lose patients for this very reason. If Swedish Hospital is allowed to build an ambulatory surgical facility on the Eastside, it would afford me and my patients the opportunity to choose the best setting based on convenience.

I would like to lend my voice in strong support of this effort. The proposal for the Certificate of Need to develop such a program in the Factoria area addresses a need for ambulatory surgery operating rooms on the Eastside.

Respectfully,

Howard S. Barnebey, M.D.

Howard Bonnihn mg

HSB:ma

EASTSIDE OFFICE 1920 116th Ave. N.E. Bellevuc, WA 98004

SEATTLE OFFICE 901 Boren Ave. Suite 1030 Seattle, WA 98104

E-MAIL office@barnebey.com

> EASTSIDE 425 990.7766

SEATTLE 206 621.8407

TOLL FREE 800 533.0434

FAX 206 447.8164

Good afternoon. My name is Pat Fredericksen and I am a Project Manager at Evergreen Healthcare on the Evergreen Surgery Center, LLC. I am here to speak on behalf of Dr. Kenneth Faw, an otolaryngologist in the greater Kirkland area and the Chairman of the Managing Board of the Evergreen Surgery Center, LLC. Evergreen Surgery Center, LLC (ESC) is jointly owned by Evergreen Healthcare and by more than fifty (50)

Eastside surgeons and anesthesiologists. Dr. Faw speaking first as the Chairman of the Managing Board of ESC, LLC wants to note for the record that in July of 2002 after a more than two year planning and development process, ESC relocated and expanded from 4 to 9 operating rooms. During the planning for expansion, we closely examined the outpatient surgery use rates and patterns of residents of East King County. In our planning, we determined that expansion of our ASC by 5 rooms would almost fully address the needs of East King through the year 2009.

Our planning evaluated many factors: for example we know that almost 75% of all surgeries occurring in Eastside facilities are outpatient, we also know that a fairly large number of surgeries on the Eastside are performed in the offices of physicians that have received an exemption from certificate of need. Each of these factors was considered in our decision to increase from 4 ORs to 9. On average, industry standards demonstrate that a freestanding OR should perform between 1000 to 1200 cases annually, depending upon mix. For example, if mostly GI cases are being done, that number should be

significantly higher. If more complex cases such as orthopedics are being done, the number would be somewhat lower. Using this rule of thumb, our ASC was built and designed to perform almost 11,000 cases. Last year we did slightly less than 5,000 cases. Clearly, we have the capacity to more than double volume—and we understand that the State's ASC projection methodology supports this, as it demonstrates that the area currently has more than an adequate supply of operating rooms.

Now, Dr. Faw would like to express his position as a physician. As an ENT physician, the vast majority of his work is done on an outpatient basis. Patients and families prefer this. It is also more efficient for he and his partners. However, it is imperative that his patients have complete access to his office pre and post procedure. Many questions arise pre-operatively, and post-operatively there are sometimes complications and always a follow-up visit. In reviewing the Swedish application it appears that the surgeons that are anticipated to use this facility are not East King physicians, but rather Swedish/downtown providers that will travel to the Eastside to perform the surgery and then head back across the bridge. Dr. Faw does not believe that this provides the best continuity or support for patients and families. Assumedly, pre and post surgical consultations will require a trip downtown for the family, as will a late night post surgical complication.

For each of these reasons, the Swedish proposal to establish an ASC in Bellevue should not be granted State approval. Again, on behalf of Dr. Faw, thank you for your consideration.

RECEIVED AT.
PUBLIC HEARING



January 31, 2003

Randall Huyck, Analyst Certificate of Need Program Department Of Health P. O. Box 47852 Olympia, WA 98504-7852

Dear Mr. Huyck:

I am otolaryngologist that practices in the greater Kirkland area and I also serve as Chairman of the Managing Board of the Evergreen Surgery Center, LLC. The Evergreen Surgery Center (ESC) is jointly owned by Evergreen Healthcare and by more than fifty (50) Eastside surgeons and anesthesiologists.

As the Chairman of the Managing Board of ESC, I want to note for the record that in July of 2002, after a more than two-year planning and development process, ESC relocated and expanded from 4 to 9 operating rooms. During the planning for expansion, we closely examined the outpatient surgery use rates and patterns of East King County residents. In our planning, we determined that expansion of our ASC by 5 rooms would almost fully address the needs of East King through the year 2009.

Our planning evaluated many factors. For example we know that almost 75% of all surgeries occurring in Eastside facilities are outpatient, we also know that a fairly large number of surgeries on the Eastside are performed in the offices of physicians that have received an exemption from certificate of need. Each of these factors was considered in our decision to increase from 4 to 9 ORs. On average, industry standards demonstrate that a freestanding OR should perform between 1,000 to 1,200 cases annually, depending upon mix. For example, if mostly Gastroenterology cases are being done, that number should be significantly higher. If more complex cases such as Orthopedics are being done, the number would be somewhat lower. Using this rule of thumb, our ASC was built and designed to perform almost 11,000 cases. Last year we did slightly less than 5,000 cases. Clearly, we have the capacity to more than double volume. We understand that the State's ASC projection methodology supports this, as it demonstrates that the area currently has more than an adequate supply of operating rooms.

As an ENT physician, the vast majority of my work is done on an outpatient basis. Patients and families prefer this. It is also more efficient for my partners and me. However, it is imperative that my patients have complete access to my office pre and post procedure. Many questions arise pre-operatively, and post-operatively there are sometimes complications and always a follow-up visit. In reviewing the Swedish application it appears that the surgeons that are anticipated to use this facility are not East King physicians, but rather Swedish/downtown providers that will travel to the Eastside to perform the surgery and then head back across the bridge. I do not believe that this provides the best continuity or support for patients and families. Assumedly, pre and post surgical consultations will require a trip downtown for the family, as will a late night post surgical complication.

For each of these reasons, the Swedish proposal to establish an ASC in Bellevue should not be granted State approval.

Thank you for your consideration.

Sincerely,

Kenneth Faw, MD

Chairman, Managing Board

Evergreen Surgery Center, LLC

13403 165th Ave. NE

Redmond, WA 98052

RECEIVED AT PUBLIC HEARING

JAN A. 2003

January 29, 2003

Randall Huyck, Analyst Certificate of Need Program Department of Health P.O. Box 47852 Olympia, WA 98504-7852

Re: Support of Swedish Medical Center Eastside ASC Proposal

Dear Mr. Huyck:

As the Chief of Orthopedic Surgery at Swedish Medical Center, I am writing in response & support of the proposal for Swedish to develop an Ambulatory Surgery Center on the Eastside of Lake Washington.

Swedish Medical Center is Washington State's largest provider of surgical services, performing over 40,000 surgical procedures per year, many of whom reside on the Eastside. We have several hundred surgeons affiliated with our medical staff, in virtually all the surgical specialty areas. Our patients come from all over the Puget Sound Region to receive care.

As I talk with my surgical colleagues at Swedish about this ambulatory surgery center proposal, we are excited about the possibility of having another surgical venue to provide easier access for our patients for their health care needs. Many of us have patients who live on the Eastside and would prefer to stay over there to receive their care. In addition, many of us surgeons and anesthesiologists also live on the Eastside, making it far more convenient for us to work there as well. As Swedish continues to grow its primary care physician base on the Eastside, this situation will become even more demanding.

Thus, on behalf of the surgeons at Swedish Medical Center, I would like to voice my strong support for a favorable review and consideration of this ambulatory surgery center proposal. Thank you for the opportunity to present my opinion on this very important project.

(206) 386 6000

Seattic, WA 98122 4307

747 Broadway

Swedish Medical Center/ Ballard Campus

Medical Center/
Fi. iil Campus

Swedish Medical Center/ Providence Campus

Swedish Home Care Services

www.swedish.org

Sincerely yours.

Dan Flugstad, M.D.

Chief of Orthopedic Surgery Swedish Medical Center



RECEIVED AT PUBLIC HEARING

January 31, 2003

Randall Huyck, Analyst Certificate of Need Program Department of Health P.O. Box 47852 Olympia, WA 98504-7852

Dear Mr. Huyck:

Evergreen Healthcare opposes the proposal of Swedish Health Services to establish a five-room ambulatory surgery center in Bellevue, as there is no need for any additional ambulatory surgery capacity in East King County. In an attempt to demonstrate need, Swedish carved out a planning area and presented use rate and capacity data that draws an inaccurate conclusion. When using the correct planning area of East King County, and the accurate associated use rates and capacity data, the planning area has a surplus of capacity.

As I understand, as a result of a relatively recent legal proceeding, the Department is required to apply its ambulatory surgery projection methodology as outlined in the administrative code when making determinations about new ASC projects. This code prohibits the Department from approving additional dedicated outpatient surgery projects until the "inpatient surgery capacity of a planning area exceeds the total inpatient OR capacity". Again, there is a surplus of inpatient or mixed-use capacity in the East King planning area.

Even if there were not a surplus of inpatient capacity, there has been such development of dedicated outpatient rooms over the past several years that the Department would determine a surplus exists in this arena as well. For example, Evergreen is part owner of the Evergreen Surgery Center (ESC). In July of 2002, the ESC expanded from 4 to 9 rooms. The planning undertaken prior to the decision to expand, projected the need for outpatient rooms through the year 2009 and built the ESC to accommodate that level of demand. In 2009, we project to be performing about 8,500 cases, which is still below the industry standard of 1,000 to 1,200 procedures per room. With 9 rooms, Evergreen's Surgery Center has capacity for almost 11,000 procedures.

Finally, the financials included in the Swedish proposal suggest that the Swedish ASC, on a per procedure basis, will be significantly more costly than existing East King ambulatory surgery options. After reviewing Swedish's year 2007 projected reimbursement and total expenses, and recognizing that the Certificate of Need

Program requires financial statements to be calculated in current year constant dollars, we determined the following:

- Evergreen's ambulatory surgery total expenses per case (fully allocated) are currently \$1,232 per case, compared to Swedish's projected \$1,520 per case. Swedish's projection of expenses is 23% higher or \$288 per each case, on a similar number of cases and operating room space.
- Evergreen's actual reimbursement per case, what we are paid, is \$1,491 versus the \$1,881 projected by Swedish, when comparing similar types of cases. In other words, Swedish projects that it will be paid 26% more than Evergreen for the same procedures.

In summary, no need exists, and Swedish has put forth no rationale to suggest that it would be a superior alternative to current providers. For these reasons, Evergreen requests that the Department deny the request of Swedish to establish an ambulatory surgery center in East King County.

Thank you for the opportunity to comment.

Julia Dillion

Sincerely,

Louis D. Filhour

Senior Vice President, Patient Care Services

Evergreen Healthcare

Home Address 103 143<sup>rd</sup> Ave SE Bellevue, WA 98007

## \* SWEDISH PHYSICIANS

RECEIVED AT PUBLIC HEARING

AN 83,2003

January 27, 2003

Randall Huyck, Analyst Certificate of Need Program Department of Health P.O. Box 47852 Olympia, WA 98504-7852

Dear Mr. Huyck:

As a group of physicians who have practiced for several years in Factoria, we support the building of an Ambulatory Surgery Center at Eastgate. Our patients routinely ask for outpatient surgical services in their community. With the tremendous growth on the east side of Lake Washington, especially in and around Issaquah, there is a growing patient demand for available outpatient services along the I-90 corridor.

Swedish Health Systems has a long-standing and solid reputation for providing high quality healthcare. With the new surgical techniques and pressure to become efficient, the trend in surgical procedures is to have them performed in an outpatient setting. Therefore we feel that Swedish's intent to build a quality Ambulatory Surgery Center at Eastgate will be in the best interest of this community.

We hope you will support Swedish with their efforts to bring much needed outpatient surgery services to our patients.

Sincerely,

Factoria Clinic

M. Bankson, M.D.

Esmail, D.O.

Grohman, M.D.

Esther F. Liu, M.D. David K. McFarland, M.D. Thi Nguyen, M.D.

Joy S. Stiefel, D.O. Wesley L. Terasaki, M.D.

Believue, WA 98006 (425) 641-4000

www.swcdish.org

Run Xue, M.D. 12917 S.E. 38thSt.

Suite 100

Anne Bankson MD

Naheed Esmail DO

Marie Grohman MD

Esther Liu MD

David McFarland MD

Thi Nguyen MD

Joy Stiefel DO

Allen Horesh MD

Wesley Terasaki MD

Run Xue MD

# APPENDIX D





An old-fashioned way to control costs; Well-run certificate-of-need programs can help rein in rising healthcare spending (Opinions-Commentary)

Article from: Modern Healthcare Article date: November 11, 2002 Author: Gaffney, Mark; Zimmerman, Martin

Byline: Mark Gaffney and Martin Zimmerman

Not all state certificate-of-need laws are created equal, but there is significant evidence that when CON is run well, it can help constrain unneeded health cost escalation and improve quality of care.

Some of the nation's largest employers-and purchasers of healthcare-have found that their healthcare costs are lower in states with CON. A recent study reported in the Oct. 16 issue of the Journal of the American Medical Association found that outcomes for openheart surgery are better in states with CON than in those without. This finding seems only natural, given the wealth of studies reporting improved outcomes when complex procedures are performed by high-volume providers.

The business and labor members of the Economic Alliance for Michigan-of which we are two of the co-chairs-agree that CON helps control costs. Unions fear that escalating health costs are eroding health benefit coverage for working people and retirees. Excessive healthcare costs also mean that there are fewer funds for wages and other employee benefits. At a time when healthcare costs are escalating by more than 10% per year, businesses and unions do not want to eliminate CON-one of the most important cost-containment tools available. Thus, it is no surprise that the entire labor movement in Michigan, a wide range of businesses and many healthcare and business associations support CON.

In analyzing their own healthcare costs, DaimlerChrysler, Ford Motor Co. and General Motors Corp.-all members of our alliance and three of the largest employers and purchasers of healthcare in the nation-reported to the Michigan Legislature about analyses of their traditional and PPO health costs. Each company examined data from states where they have many employees and retirees. They reported that in every year analyzed, they had lower per-person health costs in states with CON than in states without such laws. For example, DaimlerChrysler's per-person healthcare costs in "non-CON" Wisconsin were about triple what they were in New York, a state with a rigorous CON program.

These three separate auto studies are remarkable because they surveyed benefit plans and employee demographics that are quite similar. They also considered the level of CON regulation in each state. Typically, national studies lump all CON programs together as if they are identical when in fact there is significant variation in these laws. Also, national studies generally do not adequately recognize demographic differences among states or variations in coverage among health programs.

Michigan's CON promotes healthcare quality, a key concern for employees and employers, by requiring minimum staffing and operational standards and by concentrating services so there are high-volume providers. Medical research shows that high-volume providers are more likely to produce better outcomes for many services. In the JAMA study, the University of Iowa College of Medicine reported that Medicare patients having open-heart surgery in states without CON regulation for that service had a 21% higher inhospital mortality rate from 1994 to 1999 than patients in states that regulate open-heart surgery through CON. Simple math dictates that if you increase the number of providers, the average volume of procedures per site will be far less and could harm quality.

CON in Michigan has helped avoid contests to build duplicative and unneeded new hospitals. Although Michigan has a licensed hospital-bed occupancy rate just above 50% and still has an excess of inpatient beds, our ratio of 2.6 beds per 1,000 population is less than any other Midwestern state and is below the national average of 2.9 beds per 1,000. Under Michigan's CON program, hospitals can modernize an outdated facility but cannot build a whole new one nor add unneeded beds at existing facilities without satisfying rigorous community need requirements.

Michigan's CON program is very different from the burdensome regulatory program that some states may still have. Since Michigan's 1988 reforms, CON only focuses on projects with a high impact on cost, quality and/or access.

The playing field also was leveled: Any entity-not just hospitals-wanting to start or expand

a regulated service or construct a facility must get CON approval.

Since 1998, a bipartisan commission establishes specific CON criteria after securing recommendations from expert advisory panels. This has sharply reduced political involvement and manipulation while improving the CON application process because applicants know ahead of time what is expected of them. Previously, many hospitals were not sure of their support for CON. But because of these reforms and regular updating of the CON standards in response to changes in medical practice, most hospitals in Michigan support CON.

Michigan is not alone in recognizing the value of CON. In the past legislative session, Missouri, Ohio and Wisconsin, which had either repealed or cut back CON, considered reviving it, while Virginia tabled discussion on a proposed repeal. Meanwhile, states such as Tennessee and Maine improved their CON programs. Further, many industry groups are concerned about the relationship between costs and the ``medical arms race."

When CON is run well and run effectively, it mitigates these costly explosions and helps ensure the availability of quality, cost-effective healthcare.

Mark Gaffney is president of the Michigan State AFL-ClO. Martin Zimmerman is group vice president of corporate affairs at Ford Motor Co.

COPYRIGHT 2002 Crain Communications, Inc. This material is published under license from the publisher through the Gale Group, Farmington Hills, Michigan. All inquiries regarding rights should be directed to the Gale Group. For permission to reuse this article, contact Copyright Clearance Center.

HighBeam™ Research, Inc. © Copyright 2009. All rights reserved. www.highbeam.com

# **APPENDIX E**

## THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

Where Knowledge Informs Change

A Dartmouth Atlas Project Topic Brief

## Health Care Spending, Quality, and Outcomes

More Isn't Always Better

February 27, 2009

Elliott Fisher, MD, MPH David Goodman, MD, MS Jonathan Skinner, PhD Kristen Bronner, MA

The U.S. health care system is broken. Overall life expectancy has improved, but the burden of chronic illness is increasing, and racial and socioeconomic disparities in mortality are widening. Almost 50 million Americans lack health insurance, and coverage for many others is inadequate. The safety and reliability of care in hospitals, surgical centers, nursing homes and physician offices is far from assured. And health care costs—already the highest in the world—are growing at a rate that poses a serious threat to patients, employers and the nation.

For two decades, the Dartmouth Atlas Project has examined regional variations in the practice of medicine and in spending for health care, principally in the Medicare population. This policy brief focuses on what we have learned about the relationship between regional differences in spending and the quality of care—and the implications for efforts to reform the U.S. health care system.

### Medicare spending varies dramatically

Medicare spending in 2006 varied more than threefold across U.S. hospital referral regions (see Map 1). Research has shown that some of the variation is due to

Map Rei Mec

differences in the prices paid for similar services, and some is due to differences in illness; but even after accounting for these factors, twofold differences remain. In other words, the differences in spending are almost entirely explained by differences in the *volume* of health care services received by similar patients.

Map 1. Total Rates of Reimbursement for Noncapitated Medicare per Enrollee

by Hospital Referral Region (2006)

- \$9,000 to 16,352 (57) 8,000 to < 9,000 (79)
- 7,500 to < 8,000 (73)
- 7,000 to < 7,500 (42) 5,310 to < 7,000 (75)
- Not populated



San Francisco



Chicago



New York



Washington-Baltime



Detroit

## Why is spending higher in some regions?

More "supply-sensitive care"

Studies that have looked carefully at the additional services provided in high-spending regions have shown that the higher volume of care does not produce better outcomes for patients. Medicare beneficiaries in high-spending regions do not receive more "effective care" (services shown by randomized trials to result in better health outcomes, such as making sure that heart attack patients get proper medication). Nor do they receive more "preference-sensitive care"—elective surgical procedures which have both benefits and risks—where patients' preferences should determine the final choice of treatment. Rather, the additional services provided to Medicare beneficiaries in higher-spending regions all fall into the category of "supply-sensitive care": discretionary care that is provided more frequently when a population has a greater per capita supply of medical resources. Higher-spending regions have more hospital beds (especially intensive care unit beds), more physicians overall, and more specialists per capita. Patients in high-spending regions are hospitalized more frequently, spend more time in the ICU, see physicians more frequently, and get more diagnostic tests than identical patients in lower-spending regions.

In other words, in regions where there are more hospital beds per capita, patients will be more likely to be admitted to the hospital—and Medicare will spend more on hospital care. In regions where there are more intensive care unit beds, more patients will be cared for in the ICU—and Medicare will spend more on ICU care. And the more CT scanners are available, the more CT scans patients will receive. Conversely, in regions where there are relatively fewer medical resources, patients get less care—and Medicare spends less. So geography becomes destiny for Medicare patients.

## What are the consequences for patients?

Worse access, lower quality Using more resources and spending more money would not be controversial if it produced better health care or better outcomes. So the critical question underlying the variations in practice and spending is: What is the relationship between quantity and quality? Over the past ten years, a number of studies have explored the relationship between higher spending and the quality and outcomes of care (see Table 1). The findings are remarkably consistent: higher spending does not result in better quality of care, whether one looks at the technical quality and reliability of hospital or ambulatory care, 5-7 or survival following such serious conditions as a heart attack or hip fracture. This finding holds even when we consider changes over time; regions experiencing the greatest increase in health care spending for heart attack patients did not exhibit the most rapid improvements in health outcomes.

Higher spending also did not result in improved patient perceptions of the accessibility or quality of medical care and their experiences in the hospital.<sup>5,10,11</sup> Remarkably, in regions where the numbers of hospital beds and specialists are *greater*, physicians are *more* likely to have difficulty getting their patients into the hospital or getting a specialist referral.<sup>12</sup> Access is *worse* where there are more medical resources: a "paradox of plenty."

Recent studies have also examined the causes of the differences in practice and spending. Patients' preferences for care vary only slightly across regions. <sup>10,13</sup> Fear of malpractice suits is reported by many physicians to influence their practice, but differences in the malpractice environment explain only 10% of state variations in spending. <sup>14</sup>

As suggested above, differences in supply are clearly important. In a payment system where provider incomes depend upon the volume of services they provide, patients in regions with more physicians and hospital beds have more frequent visits to physicians and more hospitalizations. But some recent work also points to the key role of the discretionary decisions doctors make. These studies found that physicians' decisions in higher-spending regions were similar to those in low-spending regions in cases where there was strong evidence for a specific treatment. But physicians in high-spending regions were much more likely to intervene in cases where judgment was required (such as whether to admit a patient with heart failure to the hospital or whether to refer a patient with heartburn to a specialist).

In other words, the local "ecology" of health care—local capacity, local social norms and the current payment environment—profoundly influences clinical decisions. In most locales, hospitals and physicians are rewarded for expanding capacity (especially for highly profitable services) and for recruiting additional procedure-oriented specialists (such as interventional cardiologists and radiologists). And when there are more specialists or hospital beds available, primary care physicians and specialists will learn to rely on those specialists and use those beds, because it is more "efficient" from their perspective to do so. Although it is difficult to point to a single factor that "causes" higher expenditures in one region over another, there are few mechanisms currently in place to reduce these wide variations in spending; what is seen as excessive in one community (e.g., doctors owning their own CT or MRI scanners) is quite acceptable in another.

Perhaps the most counter-intuitive finding is that higher spending does not necessarily lead to better access to health care (see box), or better quality of care. Patient outcomes can actually suffer, because having more physicians involved increases the likelihood of mistakes (too many cooks spoil the soup), and because hospitals are dangerous places to be if you do not absolutely need to be there. <sup>16</sup>

Why is care worse in highspending regions?

Poorly coordinated and fragmented care

Table 1. Relationship Between Regional Differences in Spending and the Content, Quality, and Outcomes of Care				
	Higher-Spending Regions Compared to Lower-Spending Ones*			
Health care resources	Per capita supply of hospital beds 32% higher. <sup>5</sup> Per capita supply of physicians 31% higher overall: 65% more medical specialists. <sup>5</sup>			
Technical quality	Adherence to evidence-based care guidelines worse. 5,6			
Health outcomes	Mortality higher following acute myocardial infarction, hip fracture, and colorectal cancer diagnosis.			
Physician perceptions of quality	<ul> <li>More likely to report poor communication among physicians and inadequate continuity with patients.<sup>12</sup></li> <li>Greater difficulty obtaining inpatient admissions or high-quality specialist referrals.<sup>12</sup></li> </ul>			
Patient-reported quality of care	Worse access to care and greater waiting times. <sup>8</sup>			
	No difference in patient-reported satisfaction with ambulatory care. 8,10     Worse inpatient experiences. <sup>21</sup>			

<sup>\*</sup> High- and low-spending regions were defined as the U.S. hospital referral regions in the highest and lowest quintiles of per capita Medicare spending as in Fisher (2003).

# What can be done? Accountability, better evidence, and payment reform

These findings have important implications for the reform of the U.S. health care delivery system. Three underlying causes are particularly important:

- Lack of accountability for the overall quality and costs of care—and for local capacity;
- Inadequate information on the risks and benefits of many common treatments and the related assumption (on the part of most patients and many physicians) that more medical care means better medical care:
- A flawed payment system that rewards more care, regardless of the value of that care.

Each suggests important principles that any successful effort to reform the U.S. health care delivery system will have to address.

Accountability for quality, cost and capacity. Controlling the growth of health care spending while improving the quality of care will not be possible without policies that slow the growth of capacity. Several approaches are possible (some more politically feasible than others). These include regulatory approaches that limit the further growth of the acute care hospital sector (such as Certificate of Need or hospital budget approval processes) and more market-oriented approaches that foster the development of organized delivery systems that are responsible for the overall costs and quality of care for their patients.<sup>17</sup> Given the evidence on access and quality, further expansion of physician supply should not be seen as a likely means to improve access to care, and would certainly increase the overall costs of care.<sup>18</sup>

Better evidence, better performance measures. Addressing the assumption that more medical care means better medical care will require better evidence on the effectiveness of treatments, and ensuring that patients receive balanced information on the risks and benefits of different treatment alternatives. We must also improve the information on the quality and costs of care so that patients can understand that lower cost care often results in better outcomes.

Payment reform. A key cause of the current crisis of access and costs is the fee-for-service payment system (where providers are paid a fee for each service). A number of current reform proposals focus on payment reforms that would strengthen primary care (such as payments to support a "medical home" for patients organized by their primary care physicians <sup>19</sup>) and bundled payments (where a hospital and physician are paid a combined fee for all of the costs associated with a given major surgical procedure, including initial care after hospitalization <sup>20</sup>). While each addresses an important problem in our current system, they are unlikely to slow the overall growth of health care spending. Neither reverses the current incentives to expand capacity, increase the overall volume of services, or focus investments on high-margin procedures. To slow the growth of health care spending, payment reform must foster global accountability for the quality and overall costs of care for patients.

Efforts to reform the U.S. health care delivery system face serious challenges that will require multiple stakeholders to work together. One of the important insights from research on geographic variations in health care spending is that the U.S. health care system does not face a problem of scarcity. Rather, the evidence indicates that we have more than enough resources to provide high quality care for all—and to maintain provider incomes. Understanding the problem of supply-sensitive care is a critical first step.

## Thinking critically about access to care — not just the numbers.

One of the more surprising findings of the Dartmouth work is that, in regions with more physicians, both patients and physicians report greater difficulty getting needed care or needed referrals. In Massachusetts, a state with perhaps to the greatest per capita supply of both primary care and specialist physicians in the country, the Medical Society reports a "critical" shortage: 35% of family practice physicians and 48% of general internists are not accepting new patients; 70% of physicians report difficulty making specialty referrals.

The most likely explanation—in an era of relatively constrained physician fees for visits and increasing patient complexity—is that physicians are forced to manage their time much more efficiently. This efficiency may be achieved by referring more of their patients to specialists (including many that they could have managed themselves if they had more time); seeing patients they know well more frequently (they are the easiest to care for); and closing their practices to new patients (who are more complex and require more time than is covered in the fee).

The problem is not how many physicians we have; it is how we pay them and how care is organized. I have asked physician audiences what proportion of the patients they saw in their office that day needed to be seen; many will say that only a minority of their patients needed to be seen. They are seeing the others because they need to keep their offices full to pay the rent, and because they are not paid to provide care in any other way, such as through telephone calls or email.

Elliott Fisher, MD, MPH

#### **Endnotes**

- 1. Harper S, Lynch J, Burris S, Davey Smith G. Trends in the black-white life expectancy gap in the United States, 1983-2003. JAMA 2007:297:1224-32.
- Jemal A, Ward E, Anderson RN, Murray T, Thun MJ. Widening of socioeconomic inequalities in U.S. death rates, 1993-2001. PLoS ONE 2008;3:e2181.
- 3. Schoen C, Collins SR, Kriss JL, Doty MM. How many are underinsured? Trends among U.S. adults, 2003 and 2007. Health Aff (Millwood) 2008;27:w298-309.
- 4. Orszag PR, Ellis P. The challenge of rising health care costs—a view from the Congressional Budget Office. N Engl J Med 2007;357:1793-5.
- 5. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. Ann Intern Med 2003;138:273-87.
- Baicker K, Chandra A. Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care. Health Aff (Millwood) 2004.
- 7. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ. Variations in the longitudinal efficiency of academic medical centers. Health Aff (Millwood) 2004;Suppl Web Exclusive:VAR19-32.
- 8. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. Ann Intern Med 2003;138:288-98.
- Skinner JS, Staiger DO, Fisher ES. Is technological change in medicine always worth it? The case of acute myocardial infarction. Health Aff (Millwood) 2006;25:w34-47.
- 10. Fowler FJ, Jr., Gallagher PM, Anthony DL, Larsen K, Skinner JS. Relationship between regional per capita Medicare expenditures and patient perceptions of quality of care. Jama 2008;299:2406-12.
- 11. Wennberg JE, Bronner K, Skinner JS, Fisher ES, Goodman DC. Inpatient care intensity and patients' ratings of their hospital experiences. Health Aff (Millwood) 2009;28:103-12.
- 12. Sirovich BE, Gottlieb DJ, Welch HG, Fisher ES. Regional variations in health care intensity and physician perceptions of quality of care. Ann Intern Med 2006;144:641-9.
- 13. Barnato AE, Herndon MB, Anthony DL, et al. Are regional variations in end-of-life care intensity explained by patient preferences?: A Study of the US Medicare Population. Med Care 2007;45:386-93.
- 14. Baicker K, Fisher ES, Chandra A. Maipractice liability costs and the practice of medicine in the Medicare program. Health Aff (Millwood) 2007;26:841-52.

- 15. Sirovich B, Gallagher PM, Wennberg DE, Fisher ES. Discretionary decision making by primary care physicians and the cost of U.S. Health care. Health Aff (Millwood) 2008;27:813-23.
- 16. Fisher ES, Welch HG. Avoiding the unintended consequences of growth in medical care: How might more be worse? JAMA. February 3, 1999;Vol 281, No. 5.
- 17. Fisher ES, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: the extended hospital medical staff. Health Aff (Millwood) 2007;26:w44-57.
- 18. Goodman DC, Fisher ES. Physician workforce crisis? Wrong diagnosis, wrong prescription. N Engl J Med 2008;358:1658-61.
- 19. Berenson RA, Hammons T, Gans DN, et al. A house is not a home: keeping patients at the center of practice redesign. Health Aff (Millwood) 2008;27:1219-30.
- 20. Hackbarth G, Reischauer R, Mutti A. Collective accountability for medical care--toward bundled Medicare payments. N Engl J Med 2008;359:3-5.
- 21. Wennberg JE, Bronner KK, Skinner JS, Fisher ES, Goodman DC. Inpatient care intensity and patients' ratings of their hospital experiences. Health Affairs 2009 Jan;28(1):103-112.

The Dartmouth Atlas Project is funded by a broad coalition of funders, led by the Robert Wood Johnson Foundation.

Other major sources of funding include the National Institute of Aging, California Healthcare Foundation, Aetna Foundation, United Healthcare Foundation, and the WellPoint Foundation.

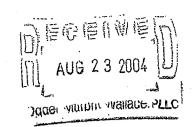
The Dartmouth Atlas

The Dartmouth Institute for Health Policy and Clinical Practice Center for Health Policy Research

Contact: Hae Jin Shin Tel: (202) 261-2888 Fax: (202) 467-5187

# **APPENDIX F**

## STATE OF WASHINGTON DEPARTMENT OF HEALTH ADJUDICATIVE SERVICE UNIT



In the Matter of:

Docket No. 03-06-C-2005CN

OVERLAKE HOSPITAL MEDICAL CENTER, a Washington non-profit Corporation; and KING COUNTY PUBLIC HOSPITAL DISTRICT NO. 2, Dba EVERGREEN HEALTHCARE, A Washington public hospital district.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF REMAND

Petitioners.

#### APPEARANCES:

Petitioner, Overlake Hospital Medical Center, by Ogden Murphy Wallace PLLC, per Donald W. Black, Attorney at Law

Petitioner, King County Public Hospital District No. 2, dba Evergreen Healthcare, by Livengood Fitzgerald & Alskog PLLC, per James S. Fitzgerald, Attorney at Law

Intervenor, Swedish Health Services, dba Swedish Medical Center, by Bennett Bigelow & Leedom P.S., per Stephen I Pentz, Attorney at Law

Department of Health Certificate of Need Program, by The Office of the Attorney General, per Richard A. McCartan, Assistant Attorney General

PRESIDING OFFICER: John F. Kuntz, Health Law Judge

The Presiding Officer, through authority delegated to him by the Secretary of

Health, conducted a hearing on January 8 and January 9, 2004, in Tumwater,

Washington. On May 27, 2003, the Certificate of Need Program denied the joint open-

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF REMAND

Page 1 of 29

Docket No. 03-06-C-2005CN

heart surgery (OHS) and percutaneous transluminal coronary angioplasty (PTCA) application filed by Overlake Hospital Medical Center and Evergreen Healthcare.

Remanded.

#### ISSUES

Did the Program correctly calculate "current capacity" in step one of the openheart surgery need methodology when analyzing the Petitioners' open-heart surgery facility application?

If the Program did not correctly calculate current capacity, must the Program engage in the rule making process under the Administrative Procedure Act (chapter 34.05 RCW) before correcting its current capacity computation?

When it consistently followed a different interpretation of the current capacity definition when approving previous applications, is the Program estopped from computing the planning area's current capacity using the "correct" definition?

Would granting the Petitioners' application cause the reduction of an existing program below the 250 OHS minimum volume standard under WAC 246-310-261(3)(c), when the existing program's OHS surgery numbers were already below the minimum volume standard at the time of the application?

### **SUMMARY OF DECISION**

The Program did not correctly apply the need forecast methodology set forth in chapter 70.38 RCW and WAC 246-310-261 when analyzing the Petitioners' open-heart surgery application. The Program failed to calculate current capacity in a manner consistent with the regulatory definition set forth in WAC 246-310-261(5)(b) when calculating step one of the forecast need methodology.

The method of calculating current capacity is a question of law rather than an issue of fact, and the Program is not estopped from correcting its calculations consistent with the regulatory language even though it consistently calculated current capacity using a different interpretation of the same regulatory language. Given the regulation is unambiguous on its face, the Program is not required to engage in the APA rule-making process before interpreting the current capacity regulatory language to the Petitioners' joint application.

The language of WAC 246-310-261(3)(c) does not directly address the issue of the reduction of an existing OHS program that has not reached the 250 OHS minimum standard. Because it is ambiguous, statutory construction rules apply in interpreting the regulation. When read in context with other chapter 246-310 WAC provisions, and given that tertiary health services providers are required to reach sufficient patient volumes to optimize provider effectiveness and quality of services, any reduction of an existing providers volume, even for an existing provider that has not reached the minimum standard, appears contrary to the legislative intent of chapter 70.30 RCW and WAC 246-310-261(3)(c).

#### PROCEDURAL HISTORY

On August 30, 2002, Overlake Hospital Medical Center and Evergreen Hospital Medical Center (the Petitioners) filed a joint application for a certificate of need to establish an open-heart surgery (OHS) and nonemergent percutaneous transluminal coronary angioplasty (PTCA) service program at the Evergreen Healthcare facility. The Program denied the joint application on May 27, 2003, and the Petitioners appealed the Program's denial decision on June 24, 2003. A three day hearing was scheduled for January 7 – 9, 2004. Swedish Health Services requested, and was granted, intervention on a limited basis under RCW 70.38.115(10) on August 29, 2003. Prehearing Order No. 1.

On November 12, 2003, the Intervenor moved to consolidate the Good Samaritan and Overlake/Evergreen proceeding, arguing the two proceedings involved similar factual and legal issues. The Program filed a memorandum in support of the Intervenor's motion on November 17, 2003. The consolidation motion was denied on the grounds that Good Samaritan and the Petitioners were not considered competing parties and the Intervenor (Swedish) had not intervened in the Good Samaritan matter. Prehearing Order No. 5.

On November 14, 2003, the Program moved to remand the decision on the Petitioners application to correct errors the Program contended it made in applying the OHS/PTCA methodology. The Program argued OHS figures from Harrison Hospital (a facility located in the same health service area that recently received an OHS/PTCA certificate of need) were not included in the WAC 246-310-261 calculations and figures relating to DRG 514 and 515 needed to be included under WAC 246-310-261(5)(e).

The Petitioners opposed the remand motion, arguing:

- (1) Neither the APA nor agency regulations permitted remand of an agency decision during an adjudicative proceeding to review agency errors;
- (2) A remand action would effectively continue the hearing date without showing any good cause existed to do so; and
- (3) The Petitioners disagree that any methodology errors exist in the present case.

The remand motion was denied on December 15, 2003. Prehearing Order No. 6.

On December 15, 2003, the Program moved for summary judgment, arguing:

- (1) The three changes made to the methodology were "correct";
- (2) The properly performed methodology mandates a denial of the application; and
- (3) The Program was not equitably estopped from correcting the methodology under Washington case law.

The Petitioners opposed the motion as untimely, as it was filed less than 28 days before the scheduled hearing date. See CR 56. Because it was unclear that the Program's most recent interpretation of WAC 246-310-261 was "correct", and given the

timing of the filing of the motion, the Presiding Officer denied the summary judgment motion on December 19, 2003. Prehearing Order No. 8.

The certificate of need application file was admitted as an exhibit at the prehearing conference. Prehearing Order No. 8. The hearing was conducted on January 8 and January 9, 2004. The parties agreed to incorporate the Good Samaritan hearing exhibits in the present hearing. OE RP at  $9-10^1$ . The Good Samaritan exhibits were:

Exhibit 1: Certificate of Need application (Good Samaritan).

Exhibit 2: OHS Current Capacity (1999 – 2001), prepared December 3, 2003 (new methodology differing from the one attached to the Program's denial decision).

Exhibit 3: DRG 514 and 515 procedures by hospital/state for 2001.

Exhibit 4: OHS Current Capacity (1999- 2001) prepared December 3, 2003 (variation of Exhibit 2, taking into account DRG codes 514 and 515).

Exhibit 5: Calculation of Good Samaritan Hospital's proposed OHS Program on Tacoma General Hospital.

Exhibit 6: Curriculum Vitae for Nayak L. Pollisar, Ph.D., dated September 22, 2003.

Exhibit 7: Regression analysis charts (using data from 1997 to 2001).

Exhibit 8: Charts regarding internal referral of cases; cumulative percentage of cases vs. average length of stay; and cumulative proportion of cases vs. DRG WT 2 for St. Joseph Medical Center and Tacoma General Hospital (re: acuity).

<sup>&</sup>lt;sup>1</sup> The parties agreed to incorporate portions of the Good Samaritan hearing transcript in the present hearing. For ease of reference the Good Samaritan report of proceedings is referred to as GS RP, and the Overlake/Evergreen report of proceedings as OE RP. Reference to the application record is identified by the abbreviation AR and the relevant page number. References to the hearing transcript will be identified by the abbreviation RP (report of proceeding), and referenced by the specific RP and relevant page number.

Exhibit 9: Comparison of Tacoma General Hospital and St. Joseph Medical

Center on case acuity (DRG WT 2).

Exhibit 10: Second Declaration of Charles Frank (with attachments). Admitted

on a limited basis.

Exhibit 11: Department of Health analysis granting OHS/PTCA certificate of

need to Harrison Memorial Hospital, dated November 2, 2001.

At the Overlake/Evergreen hearing the following additional exhibits were admitted (except where noted):

Exhibit 13: Rick Ordos declaration in lieu of testimony, dated January 8, 2004.

Exhibit 14: Petitioners' Designation of Testimony (with excerpts of testimony index and portions of Exhibits 15 – 19²), dated January 6, 2004.

Exhibit 15: Randy Huyck deposition (Good Samaritan) (10/23/03).

Exhibit 16: Randy Huyck deposition (Evergreen) (11/12/03).

Exhibit 17: Karen Nidermayer deposition (Good Samaritan) (10/20/03 and 10/21/03).

Exhibit 18: Karen Nidermayer deposition (Evergreen) (11/12/03).

Exhibit 19: Janis Sigman deposition (Evergreen) (11/12/03).

Exhibit 20: Attachment 20 – Open Heart Surgery Forecasts by HSA I Average Use Rates.

Exhibit 21: OHSD Document prepared by Karen Nidermayer (revised) 6/30/98.

Exhibit 22: Northwest Hospital – University of Washington certificate of need analysis, dated May 16, 1997.

Exhibit 23: Appendix I – Open Heart Surgery Need Methodology per WAC.

<sup>&</sup>lt;sup>2</sup> This exhibit included an excerpt of Ms. Benedict's cross examination of Karen Nidermayer from the Good Samaritan proceeding, Docket No. 03-07-C-2002CN, on December 8, 2003. Given that the Good Samaritan record was made a part of this hearing record, this two-page document was not offered or marked as a separate exhibit.

Exhibit 24: St Mary Medical Center certificate of need analysis, dated July 21. 1997. Exhibit 25: Central Washington Hospital certificate of need analysis, dated February 19, 1999. Exhibit 26: OHSD document prepared by Karen Nidermayer (revised) 9/28/92. Exhibit 27: Kadlec Medical Center - Kennewick General Hospital certificate of need analysis, dated February 6, 1998. Exhibit 28: Kadlec Medical Center - Kennewick General Hospital certificate of need settlement analysis, dated November 5, 1999. Exhibit 29: Open Heart Surgery Projections prepared by Karen Nidermayer, dated October 6, 1999. Exhibit 30: Mary Bridge Children's Hospital - Tacoma General Allenmore Hospital certificate of need application, dated March 13, 2000. Denied on grounds of relevance. Exhibit 31: Withdrawn. Exhibit 32: Open Heart Surgery Projections prepared by Karen Nidermayer (revised), dated 11/07/00. Karen Nidermayer email re: OHS data request sent December 23. Exhibit 33: 2003. OHSD document prepared by Karen Nidermayer, prepared Exhibit 34: 1/7/2004. Exhibit 35: Jody Carona Matrix of Certificate of Need Open Heart Surgery Decisions (Adult Only) 1993 -2003. Admitted on a Limited Basis. Overlake/Evergreen Certificate of Need Application file. Exhibit 36: CD-ROM disc containing open heart surgery analysis, created Exhibit 37: December 2003. Copy of Federal Register, Vol. 66, No. 148 (66 FR 39828). Exhibit 38:

Exhibit 39:

Copy of Department of Health Memorandum from Joe Campo to

Open Heart Surgery Advisory Committee, dated August 7, 1991.

Exhibit 40: Steps 5 and 6A per Karen Nidermayer's capacity method, prepared January 7, 2004.

Exhibit 41: Adult Open Heart Surgery Discharges from Overlake Hospital Medical Center (CHARS) from 1994 through 2001.

Exhibit 42: Kadiec Medical Center/Kennewick General Hospital Open-Heart Analysis (reconciliation of Step C per DOH Analysis to CHARS data provided by DOH 1996 email file).

Exhibit 43: Harrison Memorial Hospital Open-Heart Analysis (reconciliation of Step C per DOH Analysis to CHARS data provided by DOH on CD-ROM).

Exhibit 44: Recommended Standards and Forecasting Method for Certificate of Need Review of Open Heart Surgery Programs, Open Heart Surgery Advisory Committee, September 1991.

Exhibit 45: Copy of Department of Health Memorandum from Joe Campo to Open Heart Surgery Advisory Committee, dated August 26, 1991.

Exhibit 46: Summary and Analysis of Written Comments on Proposed Certificate of Need Rules on Open Heart Surgery and Nonemergent Interventional Cardiology Services, undated (ten pages).

The parties agreed to incorporate the Good Samaritan hearing record into the Overlake/Evergreen record to avoid having to repeat the testimony of witnesses presented at the prior hearing. OE RP at 6. The Petitioners reserved the right to object to portions of the Good Samaritan record, and agreed to file those objections no later than the date of filing their initial closing brief. OE RP at 7 – 8. The parties were granted permission to file briefs in lieu of closing argument. OE RP at 329 – 300; Posthearing Order No. 1. The hearing record was closed on May 3, 2004. Posthearing Order No. 2. The date for issuance of the final order was extended. Posthearing Order Nos. 3 & 4.

### **HEARING**

The Petitioners filed a joint application to develop and manage an open-heart surgery and elective intervention program located at Evergreen Hospital Medical Center (EHMC). AR at 1199. Overlake Hospital Medical Center (OHMC) began operating its own open-heart surgery and elective interventional program in November 1986. AR at 1210. EHMC would be the legal operator, but the Petitioners would establish a new entity, the Eastside Cardiac Care Alliance (ECCA), that would ultimately enter into an agreement with EHMC and OHMC and be responsible for the day-to-day operations of a single open-heart program operating at the two hospitals. The Petitioners anticipated joint management would include medical staffing, policies and procedures, quality assurance, professional education and community outreach. AR at 1211. To support this goal EHMC and OHMC entered into a Memorandum of Understanding. AR at 1219, 1230 – 1233.

Consistent with WAC 246-310-261(3)(d), the Petitioners initially provided that the OHMC cardiac surgeons would also staff the EHMC program, with a third surgeon to be recruited prior to the opening of the service. AR at 1246. The Petitioners did not anticipate any problems addressing the emergency needs of the service area population required under WAC 246-310-261(3)(e), and anticipated the higher risk patients would be referred to OHMC. AR 1246. In response to the Program's request for supplemental information, the Petitioners stated no contract existed but considered the employee-employer relationship of OHMC with its cardiac surgeons would ensure the availability of OHMC surgeons for emergency surgery on a 24/7 basis. AR 1451.

They set out those instances when they anticipated patient transfers, and provided a sample transfer agreement regarding emergency access. AR 1451, 1479 – 1482.

Open heart surgery (OHS) and percutaneous translumenal coronary angioplasty (PTCA) services are "tertiary health services", which are specialized services that meet complicated medical needs of people and require sufficient patient volume to optimize provider effectiveness, quality of service and improved outcome of care.

RCW 70.38.025(14). An applicant seeking to establish a tertiary health service must apply for a certificate of need. RCW 70.38.105(4) (f); WAC 246-310-020(1)(d)(i)(E).

OHS is a specialized surgical procedure utilizing a heart-lung bypass machine.

WAC 246-310-261. OHS does not include organ transplantation. Nonemergent PTCA services are performed in institutions having an established on-site OHS program capable of performing emergency open heart surgery. WAC 246-310-262. An OHS/PTCA application must also meet the general certificate of need review criteria set forth in WAC 246-310-210 through 246-310-240. WAC 246-310-261(2).

To assist potential applicants, the Program creates an annual OHS need forecast using a seven-step methodology. WAC 246-310-261(4). The need forecast methodology calculates need using known open heart surgery volumes in the identified service area for a three year period prior to the application and calculates a current capacity figure based on that information. Relevant information is obtained from the Comprehensive Hospital Abstract Reporting System (CHARS), a database containing information on all surgeries reported by all hospitals within the state. GH RP at 21 – 22.

Open heart surgery codes or diagnostic related groupings (DRG 104 - 109³) identify the relevant OHS surgeries. GS RP at 22. The CHARS data from the relevant three-year period is used to forecast open-heart surgery service needs four years after the concurrent review process (for example, a 1992 review forecasts 1996 need).

WAC 246-310-261(4)(a) through (g); WAC 246-310-261(5)(c).

Karen Nidermayer, a Health Services Consultant 3 with the Certificate of Need Program, was the lead analyst for the OHS/PTCA joint application filed by the Petitioners and their application was filed during the same concurrent review cycle as the Good Samaritan application. OE RP at 61. Ms. Nidermayer analyzed the application using the WAC 246-310-261 methodology. OE RP at 62. In Appendix A to the analysis (calculated using the "highest year" approach) the need forecast was for an additional 529 open-heart surgeries. OE RP at 62. However, in the body of the analysis itself, Ms. Nidermayer projected a net need of 492 OHS surgeries for the 2006 forecast year (calculated using the "highest age" approach). AR at 2109. As the forecast need figure was greater than the 250 OHS minimum volume figure, Ms. Nidermayer did not deny the Petitioners' application on this basis.

At the hearing for both Good Samaritan and the Petitioners, Ms. Nidermayer sought to correct the OHS methodology by substituting the "highest hospital" for the "highest age" approach. OE RP at 62 – 63. By way of background, when Ms. Nidermayer began with the Certificate of Need Program she approached Joe

<sup>&</sup>lt;sup>3</sup> WAC 246-310-261(5)(e) specifies that only the diagnostic related surgery codes identified in DRG 104 – 108 are to be considered for open-heart surgery purposes. It is unclear from the testimony why the Program includes DRG 109.

Campo for guidance on how to calculate current capacity for purposes of completing a forecast methodology analysis. He advised her to ignore the "highest hospital" language in WAC 246-310-261(5)(b) and use a "highest age" calculation instead, as the highest age figures were more readily available from CHARS statistical data at that time. GS RP at 85 – 87. Ms. Nidermayer subsequently used this "highest age" figure to calculate current capacity when analyzing OHS application.<sup>4</sup>

In addition to correcting the forecast methodology from the "highest age" to the "highest hospital" approach, Ms. Nidermayer sought to include the 255 OHS procedures Harrison Memorial Hospital projected it would perform under its application. OE RP at 63; see Exhibit 12. These two corrections to the current capacity calculation methodology changed the projected need from an additional 492 OHS services in 2006 to a surplus of 130 OHS services for forecast year 2006. OE RP at 63; see Exhibit 2 (the actual forecast OHS surplus figure was 137). This surplus need figure shows there is no additional OHS need existed for HSA 1 and the Petitioners' application should be denied on that ground. OE RP at 64.

As previously noted, Ms. Nidermayer found sufficient need existed to support at least one new OHS program in her analysis, and lack of need was not the basis for her decision denying the Petitioners application. Her denial decision was based on the Petitioners failure to meet the WAC 246-310-261(3)(c) standard. Ms. Nidermayer determined approval of an OHS program at EHMC (one of the Petitioners) would act to

<sup>&</sup>lt;sup>4</sup> The Overlake/Evergreen expert, Jody Carona, asserted at hearing that the CHARS data system has consistently allowed the retrieval of "highest hospital" information during the relevant time period. GS RP at 494.

reduce OHMC's program below the minimum 250 OHS volume standard and would also prevent another OHS facility, Northwest Hospital, from reaching its 250 minimum standard. OE RP at 65; AR at 2110 – 2115. While Northwest Hospital's OHS case ievel for 2001 was already below the minimum 250 OHS standard, she decided that EHMC recapturing its eight verified OHS cases would act to further reduce Northwest Hospital's OHS figure from 154 to 146 OHS procedures. Ms. Nidermayer interpreted the WAC 246-310-261(3)(c) standard required an existing facility's OHS cases not be further reduced by a new OHS application, even though that facility was already below the 250 OHS minimum standard. OE RP at 71.

The Petitioners verified EHMC referred 278 OHS patients to seven of the twelve OHS facilities in HSA 1 and contended the establishment of the new OHS facility would not reduce any of the other facilities below the minimum standard. Their conclusion was based upon total volumes of HSA 1 hospitals and the number and percentages of these volumes generated by Eastside residents. AR 1244 – 1245; AR 2111 – 2115.

Ms. Nidermayer rejected the Petitioners approach. AR at 2113 – 2115. She rejected the approach, in part, because EHMC included out of state OHS cases in its calculation and the out of state case numbers were not predictable and should not be included in the calculations. After adjusting the figure by removing the nine out of state cases, EHMC's recapture of cases it referred to OHMC would reduce OHMC's volume to 244 cases or less than the 250 OHS minimum. Additionally, Ms. Nidermayer concluded EHMC would recapture OHS cases from Northwest Hospital, with the effect that it would reduce Northwest Hospital's volume (already below the 250 OHS

minimum) even further. Finally, Ms. Nidermayer concluded the Petitioners approach did not really show any impact on other facilities. It was irrelevant to EHMC's referral patterns, so it was not helpful in determining the impact on the existing providers.

OE RP at 77.

In analyzing whether the Petitioners' application would reduce the OHS volumes for any of those seven facilities, Ms. Nidermayer found eighty-one percent of the EHMC referrals were made to two facilities, Swedish Medical Center and OHMC (its coapplicant). AR at 2111. Using a simple mathematical calculation, she determined that if EHMC recaptured 100% of its referrals to those two facilities then the Petitioners' application would cause OHMC to be reduced below the 250 OHS minimum procedures. Use of the 100% recapture rate was consistent with her approach in previous OHS application analyses, including her approach in the Good Samaritan application.

After denying the Petitioners' application for failing to comply with the WAC 246-310-261(3)(c) standard, Ms. Nidermayer applied a regression analysis to determine the projected number of OHS procedures to be performed for the health service area and the state. AR at 2114 – 2115. Neither the health service area nor the state regression analysis formed a part of her decision to deny the application, but Ms. Nidermayer chose to include them in the evaluation.<sup>5</sup>

<sup>&</sup>lt;sup>5</sup> It is unclear from the analysis why Ms. Nidermayer included material in her evaluation/analysis when it was not used in making the ultimate decision. If it was included to address an issue or concern raised in the application record, no specific reference to the record was identified in the analysis.

Ms. Nidermayer was unable to determine if the Petitioners' application complied with the WAC 246-310-261(3)(d) standard relating to the availability of board certified cardiac surgeons. She found no contract existed between EHMS and a cardiac entity to provide for cardiology services. AP 2115 – 2116. Ms. Nidermayer concluded the executed Memorandum of Understanding did not provide sufficient information for that purpose. AP at 2116. While the Petitioners did provide a sample transfer agreement, the Program concluded it did not contain sufficient information to allow a determination if the Petitioners' program would comply with WAC 246-310-261(3)(e).

Gary Bennett, the Program's director of facilities and services licensing, denied the Petitioners application based on Ms. Nidermayer's analysis. His normal practice is to rely on the expertise and determinations made by the analysis. OE RP at 24 – 25. Any review and analysis of an OHS application is based upon the relevant statutes and regulations. Staff and applicants may also refer to prior OHS written determinations, as there is no written policy manual on how to apply any specific methodology for calculation of need. OE RP at 23 – 24. The Program's goal is to ensure and maintain a consistent approach in reviewing applications. Mr. Bennett notes the Program would not continue to apply any methodology it knows to be incorrect simply to be consistent with its past decisions. OE RP at 36.

Following her employment with the Certificate of Need Program, Jody Carona created a consulting firm in 1981, Health Facilities Planning and Development, which has participated in five open-heart surgery applications since the 1992 rule change. This includes the OHS application by the Petitioners.

The open heart surgery rule was last amended in 1992, and Ms. Carona participated on a technical advisory subcommittee to develop a forecast methodology. OE RP at 225. One issue discussed by the subcommittee was how to calculate capacity. Four different approaches were considered. OE RP at 227 – 228. Three of the four approaches identified were the highest year (selecting the calendar year with the highest OHS volume from the three year calendar period), highest age (the total of the highest OHS age-specific use rate amounts from each of the three calendar years within the period) and highest hospital (the total of the highest OHS volumes from each of the facilities within the three year period). The subcommittee found none of the approaches was considered empirically superior to the other. OE RP at 228.

Ms. Carona described capacity as the maximum amount of throughput volume the existing provider could accommodate. OE RP at 229. From a policy standpoint, she believes using the highest hospital approach allows for a significant overstatement of capacity, as a one-year spike in a hospital's figures allows for the overstatement of capacity. OR RP at 234 – 235. According to statistician Nayak Pollisar, Ph.D., the highest hospital approach is a worst case interpretation, as it is unlikely that the maximum number across the board for each hospital will be achieved. GS RP at 236 – 237. Ms. Carona considers the highest year calculation as the most reasonable approach.

Nonemergent PTCA procedures and all other nonemergent interventional cardiology procedures shall be performed in institutions which have an established on-site OHS program capable of performing emergency open heart surgery.

WAC 246-310-262. Since its joint application was not consistent with the criteria in WAC 246-310-261, the Petitioners' application for PTCA services was denied.

AR 2122.

Because the Petitioners' application was not consistent with the standards under WAC 246-310-261(3), the Program found it was not consistent with the requirements under the general certificate of need requirements under WAC 246-310-210 through 246-310-240. AR at 2123 – 2134. In deposition, and again at hearing, Ms. Nidermayer stated if the Petitioners met the WAC 246-310-261 requirements she would find the Petitioners met the general CON requirements. Exhibit 18; OE RP at 172 – 173.

### LEGAL ANALYSIS

The Department of Health is authorized and directed to implement the certificate of need program. RCW 70.38.105. "The [Certificate of Need] program seeks to control costs by ensuring better utilization of existing institutional health services and major medical equipment. Those health care providers wishing to establish or expand facilities or acquire certain types of equipment are required to obtain a CN, which is a nonexclusive license." St. Joseph Hospital and Health Care Center v. Department of Health, 125 Wn.2d 733, 735 – 736 (1995). Reduced to its simplest terms, the Program controls health care costs by granting or denying of a certificate of need application. An OHS applicant must show it complies with the need methodology requirements under WAC 246-310-261(4), the standards under WAC 246-310-261(3) and the general need requirements under WAC 246-310-210 through 246-310-240.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF REMAND

Page 17 of 29

Docket No. 03-06-C-2005CN

The Program initially found additional OHS need existed in Health Service Area 1 in the 2006 forecast year and it did not deny the Petitioners' application for this reason. The Program denied the Petitioners' application because it failed to comply with three of the standards contained in WAC 246-310-261(3). First, granting the Petitioners' application for an OHS program at EHMC would act to reduce OHMC and Northwest Hospital's OHS volume below the minimum volume standard under subsection (3)(c). Second, in its applications the Petitioners failed to demonstrate it would have at least two board certified cardiac surgeons as required under subsection (3)(d). Finally, the Program found the Petitioners did not have a sufficient plan for facilitating emergency access under subsection (3)(e). The Petitioners disagreed with the Program's analysis on these issues and appealed the decision.

In its remand motion, and at hearing, the Program sought to correct the methodology it used to calculate need in the analysis. It argued WAC 246-310-261(5)(b) required the calculation of current capacity using the highest hospital, rather than the highest age, approach. It also argued the clear language of WAC 246-310-261(4)(a) required the inclusion of 255 OHS assumed volume from Harrison Memorial Hospital in its calculations. If need was calculated using this approach it would reveal surplus OHS capacity existed in the forecast year and the Petitioners' application should be denied on those grounds. The Petitioners dispute the Program's current capacity calculations were a "mistake". They argue the Program

<sup>&</sup>lt;sup>6</sup> In its post hearing brief the Program conceded that using OHS surgeries on out of state patients could be used in the calculations, and no longer claimed that the Petitioners' proposed program would fail to comply with WAC 246-310-261(3)(c) by reducing OHMC surgeries below the minimum standard. Program Post Hearing Brief, at 12 – 13.

must use the highest age method, a method it has consistently used in reviewing previous OHS applications. The Petitioners argue by its consistent use of the highest age method, the Program is now estopped from using the highest hospital method absent the amendment of WAC 246-310-261(5)(b) following the required APA rule making process.

The same issues were recently addressed in the case *In re Good Samaritan Hospital*, Docket No. 03-07-C-2002CN (July 16, 2004) (*Good Samaritan*). In that decision the Presiding Officer held:

- 1. The plain language of WAC 246-310-261(5)(b) defines "current capacity" using the highest hospital approach rather than the highest age or highest year approaches.
- 2. The Harrison Memorial Hospital OHS program capacity must be included in any calculation of current capacity.
- 3. The Program is not estopped from using the correct current capacity approach even though it previously used an incorrect (highest age) approach in analyzing previous OHS applications.

Good Samaritan, at 26-29. Based on the reasoning of that decision, current capacity must be calculated using the highest hospital approach. As the adjudicative proceeding does not supplant the certificate review process, the matter should be remanded to address this issue.

The Petitioners argue granting its application will not reduce OHMC and Northwest Hospital's programs below the WAC 246-310-261(3)(c) minimum standard. The Program now agrees with the Petitioners that granting its application would not reduce the number of OHMC's open heart surgeries below the minimum standard. Program Post Hearing Brief, at 13.

The parties disagree whether reducing Northwest Hospital's open heart surgery numbers from 151 to 143 would cause the Petitioners' program to fail to comply with WAC 246-310-261(3)(c). The Program argues its interpretation is correct because the Petitioners proposed program undeniably would reduce the Northwest Hospital volume. Program Post Hearing Brief, at 13. The Program argues laws should be construed to effectuate statutory intent (i.e., preventing an OHS provider from reaching the 250 OHS minimum standard has the same effect as reducing it below the standard) and laws should be construed to avoid unlikely, absurd or strained consequences. Program Brief, at 13 (case citations omitted). The Program argues its interpretation (falling within its area of expertise) should be given substantial weight. Id.

The language of WAC 246-310-261(3)(c) provides "no new program shall be established which will reduce an existing program below the minimum volume standard." The minimum standard, pursuant to WAC 246-310-261(3)(a), is 250 OHS procedures. Since its application did not reduce Northwest Hospital below the minimum standard (as it was already approximately 99 to 107 surgeries below the OHS minimum standard), the Petitioners argue their application does comply with the language of the regulation. Petitioners' Initial Post Hearing Brief, at 12 – 14.

WAC 246-310-261(3)(c) states "no new program shall be established which will reduce an existing program below the minimum volume standard." The Petitioners argue the regulation is plain on its face and unambiguous, and therefore must be given its plain and obvious meaning. Petitioners' Initial Post Hearing Brief, at 12 (case citation omitted). The Program disagrees. In reviewing the WAC 246-310-261(3)(c), the

language of that subsection does not specifically address the issue in question, that is how to address an OHS facility which is already below the 250 OHS minimum standard.

A court interpreting a statute must first determine whether the statute's language is ambiguous, that is one whether the language is capable of more than one reasonable interpretation. *Gorman v. Garlock, Inc*, 121 Wn.App. 530, 541 (citations omitted). The question is whether WAC 246-310-261(3)(c) has more than one reasonable interpretation. Each party provides what it considers a reasonable interpretation.

In interpreting WAC 246-310-261(3)(c), the Program appears to distinguish between those situations where an existing program's surgical numbers are below the 250 OHS minimum standard and the new program does not recapture any OHS procedures from that existing program (see Exhibit 12) or where, as here, the new program does recapture OHS procedures from the existing program. The Petitioners contend WAC 246-310-261(3)(c) applies only in those situations where a new provider reduces an existing provider's OHS procedure level below the 250 OHS procedure level. In the event the existing provider is currently performing below the 250 OHS minimum level, the regulation does not apply (or reduce the existing program), even if the new program recaptures OHS procedures from that existing provider. Were the Presiding Officer to read WAC 246-310-261(3)(c) independent of the remaining sections of chapter 246-310 WAC, the Petitioners argument would carry greater weight.

<sup>&</sup>lt;sup>7</sup> A review of chapters 70.38 RCW and 246-310 WAC does not reveal that the Program has any authority, once a certificate of need is awarded to a provider, to "close down" an OHS program that does not meet the 250 OHS minimum standard. It is unclear to the Presiding Officer why that authority does not exist, given that the 250 OHS procedure standard is deemed necessary to maintain OHS surgical competency levels.

The primary goal of the statutory construction is to carry out legislative intent.

Cockle v. Department of Labor & Industries, 142 Wn.2d 801, 807 (2001). In determining legislative intent, a court must consider the entire sequence of all statutes related to the same subject matter. Boise Cascade Corp. v. Washington Toxics

Coalition, 68 Wn.App. 447, 455 (1993). The legislative intent in chapter 70.38 RCW, in relevant part, is to develop health services in a planned, orderly fashion, consistent with identified priorities and without necessary duplication or fragmentation.

RCW 70.38.015(2) (Emphasis added). It is necessary to give effect to all of the statutory language in construing a statute so that no portion is rendered meaningless or superfluous. Davis v. Department of Licensing, 137 Wn.2d 957, 963 (1999).

Open heart surgery programs are required to perform a minimum of 250 OHS procedures per year. WAC 246-310-261(3)(a). Open heart surgery, a tertiary health service, requires sufficient patient volume to optimize provider effectiveness, quality of service and improve outcomes of care. WAC 246-310-261-010. An OHS program shall meet the general standards in WAC 246-310-210 through 246-310-240 in addition to the specific open-heart surgery standards in order to receive a Certificate of Need. WAC 246-310-261(2). The population to be served must have a need for the services of the type proposed and the services are not or will not be sufficiently available or accessible to meet that need. WAC 246-310-210(1). The accessibility of such health services includes assessing the efficiency and appropriateness of the use of existing services and facilities similar to those proposed. WAC 246-310-210(1)(b).

The Program's practice of considering OHS program which are currently below the 250 OHS standard appears to include situations where (as here) a new provider recaptures OHS surgeries from an existing, but below standard, OHS provider. This reduces that existing provider's ability to maintain or achieve sufficient patient volumes and affects that provider's effectiveness. Where a new provider does not recapture any OHS surgeries from an existing, but below standard, OHS provider, that provider's ability to maintain or achieve sufficient patient volumes and effectiveness are not affected. Under that analysis, the Program's interpretation of WAC 246-310-261(3)(c) appears the more appropriate approach.

The Program determined it could not conclude whether the Petitioners complied with the WAC 246-310-261(3)(d) and (3)(e) standards. After reviewing the documentation contained in the Petitioners' application, the Presiding Officer agrees. On remand the Petitioners should be allowed additional time to provide documentation in support of these two requirements.

As stated in the Good Samaritan matter, the certificate of need adjudicative proceeding is not to supplant the certificate of need review process but to assure that the procedural and substantive rights of the parties have been observed and that the factual record supports the Program's analysis and decision. See Ear, Nose, Throat and Plastic Surgery Associates, Docket No. 00-09-C-1037CN (April 17, 2001), Prehearing Order No. 6, at page 8. For that reason the matter will be remanded so the Program can correct its analysis, and/or the Petitioners can supplement their application, consistent with this decision.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF REMAND

Page 23 of 29

Docket No. 03-06-C-2005CN

## I. FINDINGS OF FACT

- 1.1 The Petitioners submitted a joint application to establish OHS/PTCA services in Health Service Area I in August 2002. Analysis of this application was assigned to Program analyst Karen Nidermayer.
- 1.2 In Appendix A to the analysis, the 2006 projected need for additional OHS services was calculated to be 529 additional OHS procedures. Current capacity for this projection was calculated using the highest year approach and did not include the estimated OHS volumes for the Harrison Memorial Hospital application granted by the Program in November 2001.
- 1.3 In the body of the analysis Program analyst Karen Nidermayer used the highest age, rather than the highest year, approach when calculating current capacity. She projected a net need of 492 additional OHS surgeries in forecast year 2006. In calculating this net need figure she did not include the estimated OHS volume for the Harrison Memorial Hospital application granted by the Program in November 2001.
- 1.4 The Program made two mistakes in calculating "current capacity". It used the "highest age" rather than the "highest hospital" approach required under WAC 246-310-261(5)(b). The Program did not include the Harrison Memorial Hospital OHS assumed volume in calculating current capacity required under WAC 246-310-261(4)(a).
- 1.5 Utilizing the "highest hospital" approach, and calculating current capacity to include Harrison Memorial Hospital's assumed volume, results in a surplus OHS capacity of 137 surgeries for health service area 1 for the 2006 forecast year.

- 1.6 In the absence of need for additional OHS capacity, the Petitioners application failed to meet the PTCA requirements under WAC 246-310-262, and the general certificate of need requirements under WAC 246-310-210 through 246-310-240.
- 1.7 Granting an OHS application to EHMC reduces the minimum OHS volume for Northwest Hospital from 151 to 143 surgeries.
- 1.8 A review of the Petitioners' application does not provide sufficient information to determine whether they complied with the WAC 246-310-261(3)(d) and (3)(e) requirements.

# II. CONCLUSIONS OF LAW

- 2.1 The Department of Health is responsible for managing the certificate of need program under chapter 70.38 RCW. WAC 246-310-010. An applicant denied a certificate of need has the right to an adjudicative proceeding. WAC 246-310-610(1); RCW 34.05.413(2). A certificate applicant contesting a Department decision must file a written application for a proceeding within twenty-eight days of receipt of the department's decision or reconsideration. WAC 246-310-610(3). Chapters 34.05 RCW and WAC 246-10 govern the proceeding.<sup>8</sup>
- 2.2 The Petitioners filed a joint certificate of need application to establish OHS/PTCA services in health service area 1. The application was denied on May 27, 2003, and the Petitioners appealed the Program's decision denying their application on June 24, 2003. The Petitioners' request was timely.

<sup>&</sup>lt;sup>8</sup> WAC 246-310-610(3) provides chapter 246-08 WAC governs the proceeding. 246-10 WAC has replaced chapter 246-08. WAC 246-10-101(3).

- 2.3 The burden of proof in certificate of need cases is preponderance of the evidence. WAC 246-10-606. In all cases involving an application for licensure, the applicant shall establish it meets all applicable criteria. WAC 246-10-606. Evidence should be the kind upon which reasonably prudent persons are accustomed to rely in the conduct of their affairs. RCW 34.05.452(1); WAC 246-10-606.
- 2.4 To be granted a certificate of need, an open-heart surgery program shall meet the standards in [WAC 246-310-261] in addition to applicable review criteria in WAC 246-310-210 through WAC 246-310-240. WAC 246-310-261(2).
- 2.5 A planning area's current capacity for open-heart surgery equals the sum of the highest reported annual volume for each hospital within the planning area during the most recent available three years. WAC 246-310-261(5)(b). In those planning areas where a new program is being established, the assumed volume of that institution will be the greater of either the minimum volume standard or the estimated volume described in the approved application and adjusted by the department in the course of review and approval. WAC 246-310-261(4)(a).
- 2.6 WAC 246-310-261(5)(b), as written, requires current capacity as the highest reported annual volume for each hospital, and requires the use of the "highest hospital" method in calculating that number. *In re Good Samaritan Hospital*, 03-07-C-2002CN (July 16, 2004). That number is then used to calculate step one of the forecast need methodology under WAC 246-310-261(4). Because the Program did not use the "highest hospital" method to calculate current capacity, it failed to correctly calculate the OHS forecast need amount for the 2006 forecast year.

- 2.7 WAC 246-310-261(4)(a) requires the calculation of current capacity include the minimum or estimated volume of a new program where such program is being established. A new program (Harrison Memorial Hospital) was established in 2001 after the Petitioners application was filed and should have been used in calculating current capacity. The Program failed to do so and therefore did not correctly calculate current capacity in analyzing this application.
- 2.8 The language in WAC 246-310-261(5)(a) is unambiguous and requires calculation of current capacity using the "highest hospital" method. The language in WAC 246-310-261(4)(a) is unambiguous, and requires the calculation of current capacity using the 255 OHS assumed volume of Harrison Memorial Hospital. Because the regulation is unambiguous it is not subject to the rules of statutory interpretation, and must be applied by the Program as written. Because the issue raised on appeal speaks to a matter of law rather than an issue of fact, the Program is not estopped from correctly applying the language of the relevant regulation.
- 2.9 WAC 246-310-261(3)(c) provides no new OHS program shall be established which will reduce an existing program below the minimum volume standard. The regulation does not specifically address the situation where an existing program is currently performing below the 250 OHS minimum standard. The regulation is therefore ambiguous and subject to the rules of statutory interpretation.
- 2.10 Based on the legislative intent contained in RCW 70.38.015(2), and interpreting WAC 246-310-261(3)(c) in conjunction with the other regulatory sections contained in 246-310 WAC, an applicant can reduce the OHS volume of an existing

program, even though the existing program's OHS volume has not achieved the 250 OHS minimum standard. By reducing Northwest Hospital's OHS standard from 151 to 143, the Petitioners application fails to comply with the WAC 246-310-261(3)(c) standard.

- 2.11 The language of WAC 246-310-261(3)(d) provides an OHS program shall have at least two board certified cardiac surgeons, at least one of whom is available for emergency surgery twenty-four hours a day. WAC 246-310-261(3)(e) provides that institutions with OHS program shall have plans for facilitating emergency access to open heart surgery services at all times for the population they serve.
- 2.12 Based on a review of their application, and supplements to that application, there is insufficient evidence to determine whether the Petitioners meet the standards contained in WAC 246-310-261(3)(d) and (3)(e).

### III. ORDER

Based on the foregoing Procedural History, Findings of Fact and Conclusions of Law, the Certificate of Need Program's determination denying the Petitioners' openheart surgery application is REVERSED and the application REMANDED to the Program for processing consistent with the terms of this Order. The recalculation shall be filed with the Adjudicative Service Unit within 28 days of the date of service of this order.

Dated this

\_ day of August, 2004.

JOHN F. KUNTZ, Health Law Judge

Presiding Officer

## **NOTICE TO PARTIES**

This is not a final order issued under RCW 34.05.461. A final order based upon these Findings of Fact shall be issued after receipt of the recalculation completed in accordance with this order.

The recalculation shall be filed with the Adjudicative Service Unit within 28 days of the date of service of this order. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).